

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14097

## CERTIFICATE OF DEATH

Reg. Dist. No.

13976

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Greene</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zenia</u> 72 x. 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>		d. STREET ADDRESS <u>135 Dayton Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Clark</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1873</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	9. AGE (In years last birthday) <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>West Chester, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi F Allen</u>		14. MOTHER'S MAIDEN NAME <u>Alice Denman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Paint Branch Nursing Home Records</u>	
17. INFORMANT <u>Paint Branch Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>Prostatic hypertrophy with Urinary Retention</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <input type="checkbox"/> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>Nov 9</u> , 19 <u>59</u> , to <u>Dec 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 6</u> , 19 <u>59</u> , and that death occurred at <u>1:11 A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>James M. Whitaker MD</u> ADDRESS (Street, city or town, state) <u>M.D. 2201 Carroll Ave</u> DATE SIGNED <u>12-9-59</u> PHYSICIAN'S NAME (Type) <u>James M. Whitaker MD</u> <u>TC Kame Pank MD</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> 22b. DATE THEREOF <u>12-10-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAND CEMETERY</u> 22d. LOCATION (City, town, or county) (State) <u>XENIA OHIO</u> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos. Hawley's Sons Inc. 1756 P. Ave. N.W.</u> 24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kame</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14021

CERTIFICATE OF DEATH

13977

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) b. STATE <u>Md</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7522 Jackson Ave.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
				f. STREET ADDRESS <u>7522 Jackson Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>(Wm)</u> Last <u>ANDERSON</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Dec 1879</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Ernest J. Wolfe</u>				Address <u>7522 Jackson Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 14</u> , 1959, to <u>Dec 31</u> , 1959, that I last saw the deceased alive on <u>Dec 30</u> , 1959, and that death occurred at <u>2 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6911 5th St NW Wash DC</u> <u>12/31/59</u> ACTUAL SIGNATURE <u>O. B. Little</u> PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>31 Dec 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 47 Maryland Ave NE</u>				ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>							

CERTIFICATE OF DEATH

1903

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BUREAU OF VITAL STATISTICS

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14098

## CERTIFICATE OF DEATH

13978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>FAIRFAX</b> VIRGINIA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>21 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>1614 SHELDON DRIVE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>B</b> Last <b>ANDERSON</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 SEPTEMBER 1922</b>	
9. AGE (In years lost birthday) <b>37 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>							
13. FATHER'S NAME <b>GADDY MOORE</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>N/A</b>			
INFORMANT <b>JAMES O ANDERSON (HUSBAND)</b>				Address <b>1614 Sheldon Dr Alexandria, Virginia</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASTROCYTOMA CEREBRUM</b> DUE TO (c) <b>8 MOS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>20 DECEMBER 19 59</b> to <b>21 DECEMBER 19 59</b> , that I last saw the deceased alive on <b>21 DECEMBER 19 59</b> , and that death occurred at <b>0235A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b>				DATE SIGNED <b>21 DECEMBER 59</b>			
ACTUAL SIGNATURE <b>Reginald P. Mc Manus</b> M.D.							
PHYSICIAN'S NAME (Type) <b>REGINALD P. MC MANUS, CAPT, USAF, MC</b>				<b>USAF HOSPITAL ANDREWS, WASH 25, DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/24/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedarvale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mullins, So. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Douglas M. Duncanson</b>				24a. REC'D BY REGISTRAR <b>Fitzgerald Funeral Home</b> <b>3245 Wilson Blvd. Arlington Va</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13979

14022

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Lanham</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>433 Main Street</u>		d. STREET ADDRESS <u>433 Main St</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Louise Arnold</u>		4. DATE OF DEATH <u>December 13 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28, 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Glenview, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Sheppard</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Ellen Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Samuel Arnold</u>		Address <u>433 Main St Lanham Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V Dis.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Arteriosclerosis</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/19</u> , 19 <u>39</u> , to <u>12/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/9</u> , 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.		ADDRESS (Street, city or town, state) <u>Lanham Md</u>	
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		DATE SIGNED <u>12/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Witt Sanderson</u>		ADDRESS <u>Lanham, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

1913

Page 1 of 1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13980

14023

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P.K.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Christine</b> First Middle Last <b>Ashton</b>		4. DATE OF DEATH <b>Dec.</b> Month <b>19</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1889</b> ?
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Thomas Ashton</b>		Address <b>5711 Jay St N.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X</b> DUE TO <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Cervix</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Nov. 23</b> 19 <b>59</b> Hour a. m. <b>12.30</b> p. m. <b>P.M.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 19 19 59</b> to <b>Dec. 19 19 59</b> , that I last saw the deceased alive on <b>Dec 19 19 59</b> , and that death occurred at <b>12.30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>—</b> DATE SIGNED <b>12/19/59</b>			
ACTUAL SIGNATURE <b>Lucas R. Greco</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. W. Greco</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington</b> ADDRESS <b>4925 Deane Ave N.E.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kinn</b>	

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CERTIFICATE OF DEATH

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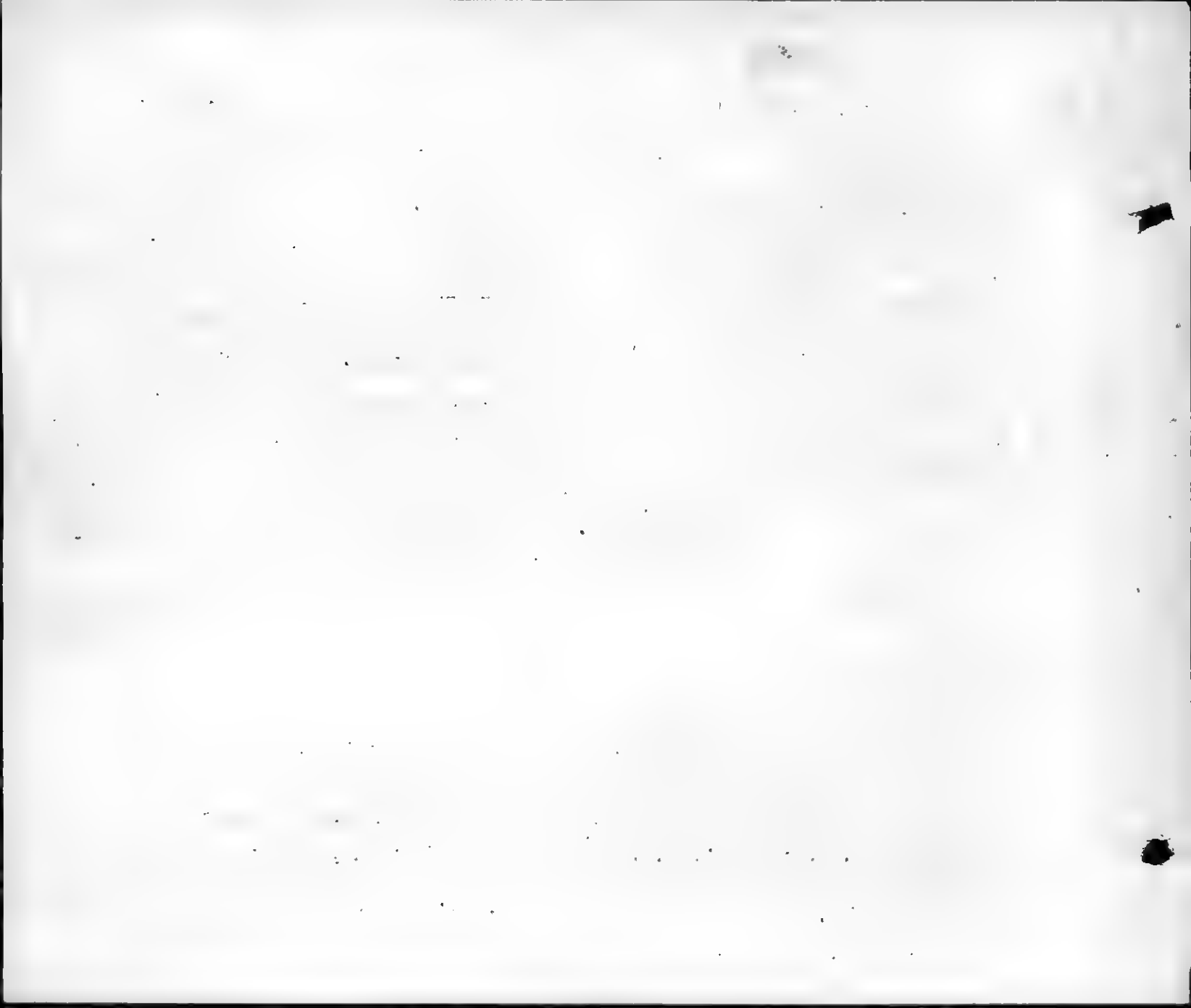
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 12 File G254 1-19-60 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

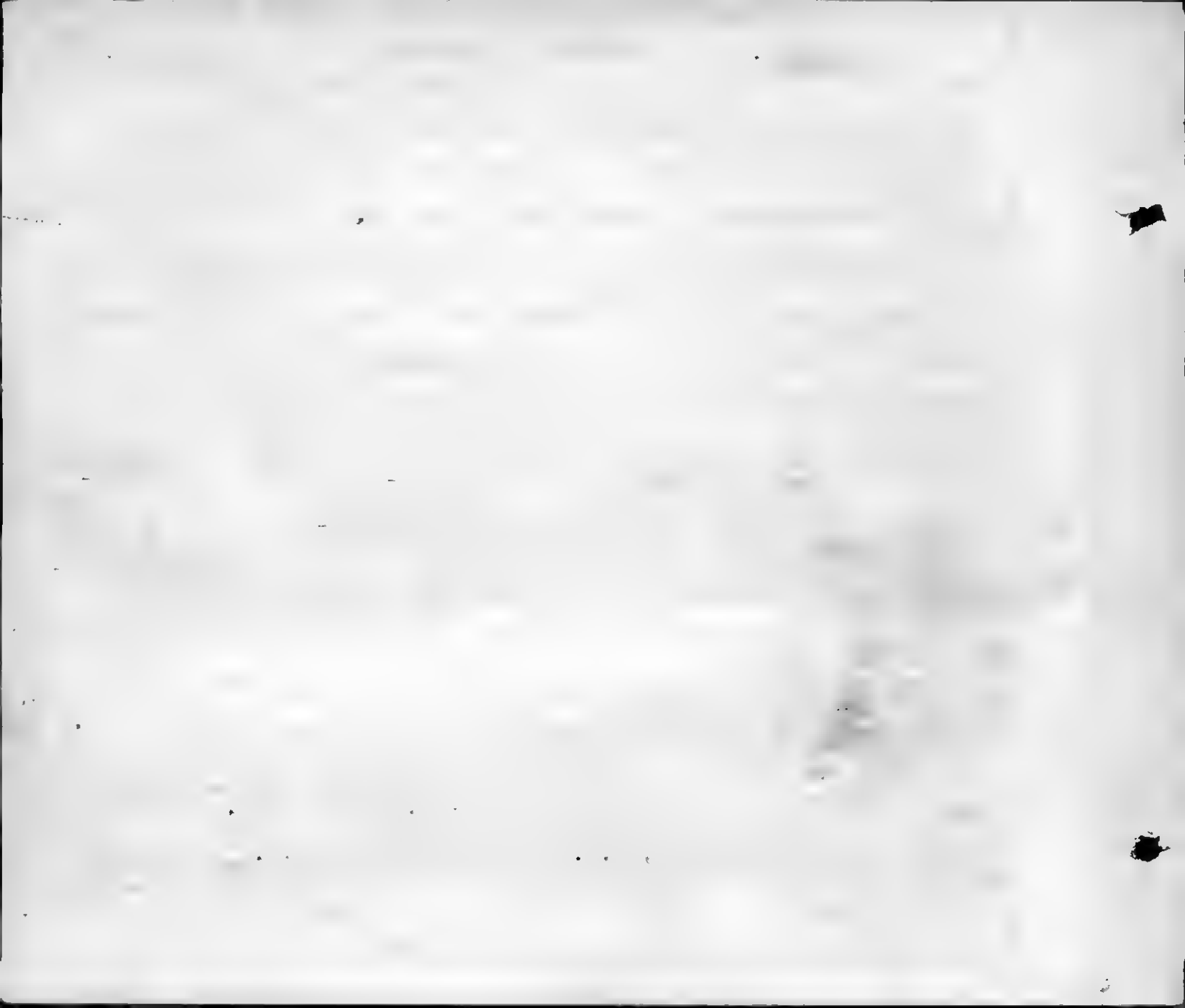
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>42 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>2824 64th. Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Laurette</b> First <b>A.</b> Middle <b>BAGNALL</b> Last		4. DATE OF DEATH <b>December 21, 1959</b> Month <b>December</b> Day <b>21</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-21</b>
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR <b>38</b> Months	11. IF UNDER 24 HRS <b>38</b> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
10c. BIRTHPLACE (State or foreign country) <b>Somerset</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>John Joseph Bagnall, Husband</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 17 + <b>12-19-59</b> DUE TO <b>Thrombosis of Inferior Venal Cava</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Carcinomatosis</b> DUE TO <b>Carcinoma of the Thyroid Gland</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 week</b> <b>7 months</b> <b>7 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>59</b> , to <b>December 21, 1959</b> , that I last saw the deceased alive on <b>12-19-59</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Albert Roth</b> M.D.		ADDRESS (Street, city or town, state) <b>5510 Madison Street</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. Albert Roth, M.D.</b>		<b>Riverdale, Maryland</b>	
22a. BURIAL, CREMAT., ON. REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b> ADDRESS <b>Mt. Rainier Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION





## CERTIFICATE OF DEATH

Reg. Dist. No.

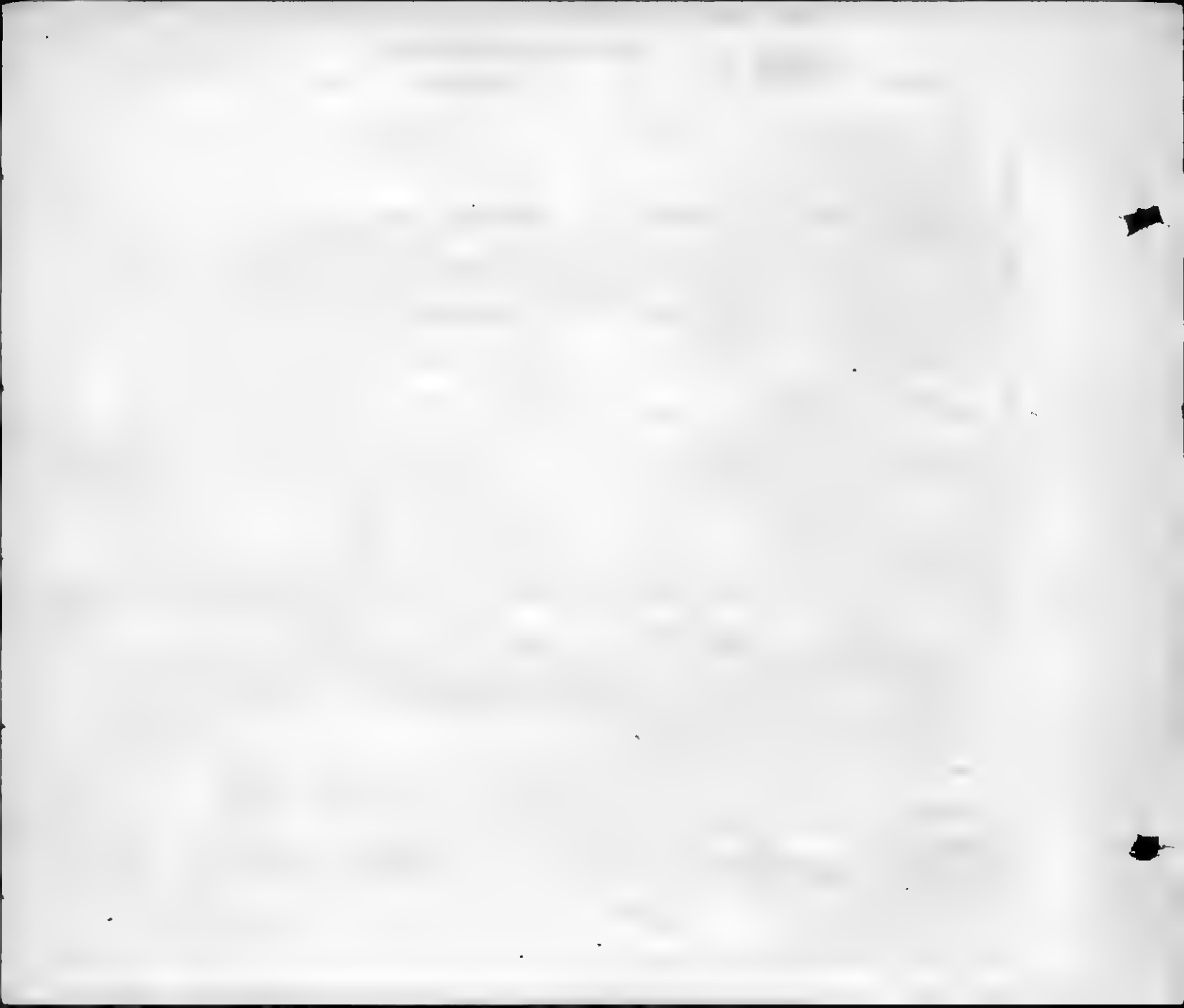
13982

13025

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Ireland Memorial</u>				1d STREET ADDRESS <u>425 Prince George St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>R</u> Last <u>Bauer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30 1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photography</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Bauer</u>				14. MOTHER'S MAIDEN NAME <u>Joanne Kaumer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma of Cecum</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 30</u> , 19 <u>55</u> , to <u>Dec 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>59</u> , and that death occurred at <u>5:10 P. M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Robert S. McCeney</u> M.D.				ROBERT S. MCCENEY M.D. 402 MAIN ST. LAUREL, MD.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kraus</u>				ADDRESS <u>Laurel, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

13982

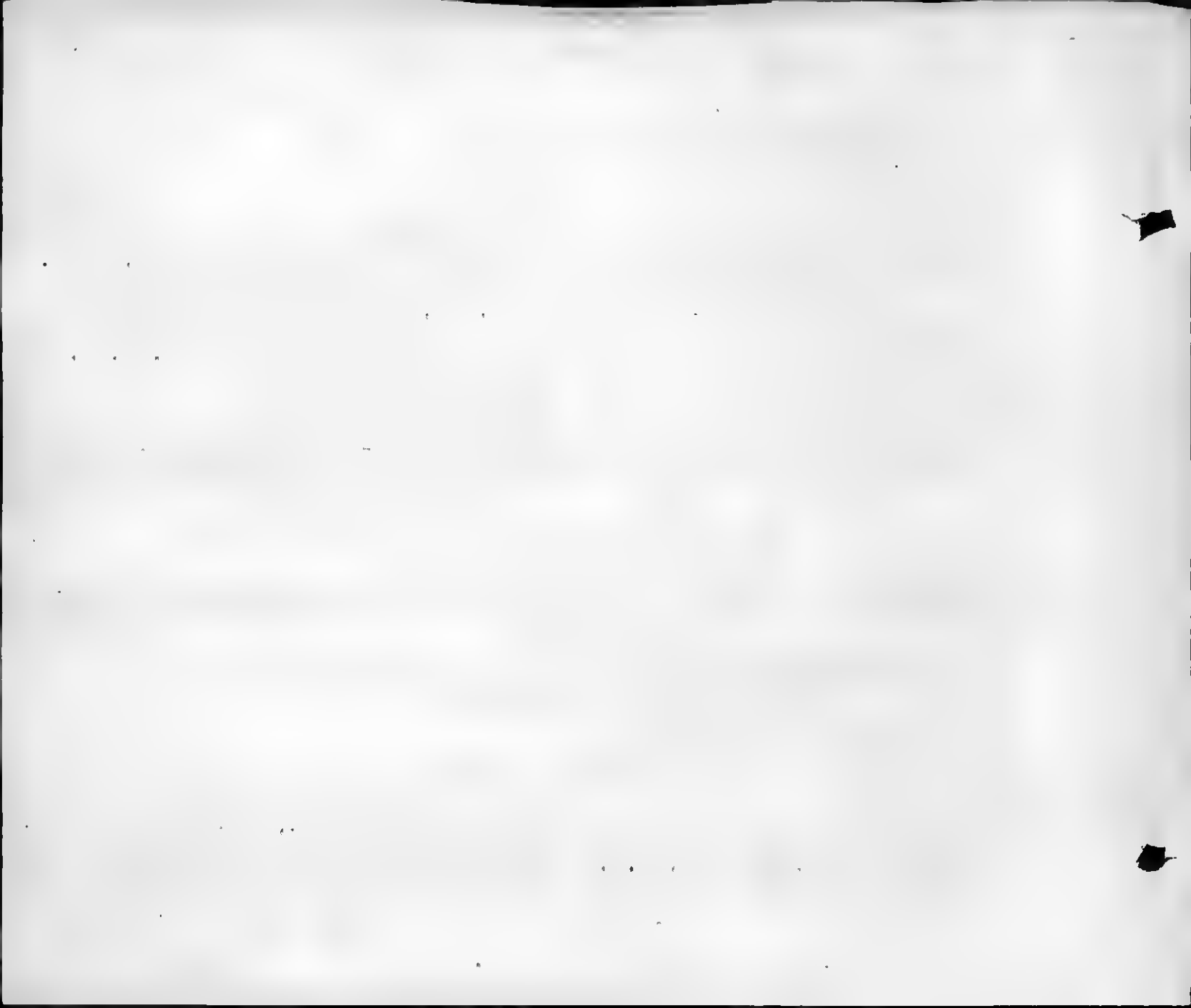
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION - - - - -		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Seton</b> Last <b>Belt</b>		4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Seton Belt</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Lee Bowie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unkwn</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William Brooke--Upper Marlboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease 2 yrs</b> DUE TO (c) <b>Diabetic Mellitus (mild)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 7, 1957</b> to <b>2-26-6, 1957</b> , that I last saw the deceased alive on <b>2-26-4, 1957</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>James E. Janner M.D. Upper Marlboro, Maryland 12/7/59</b>			
ACTUAL SIGNATURE <b>James E. Janner</b>		PHYSICIAN'S NAME (Type) <b>James G. Sasser, M.D. Upper Marlboro, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leeland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

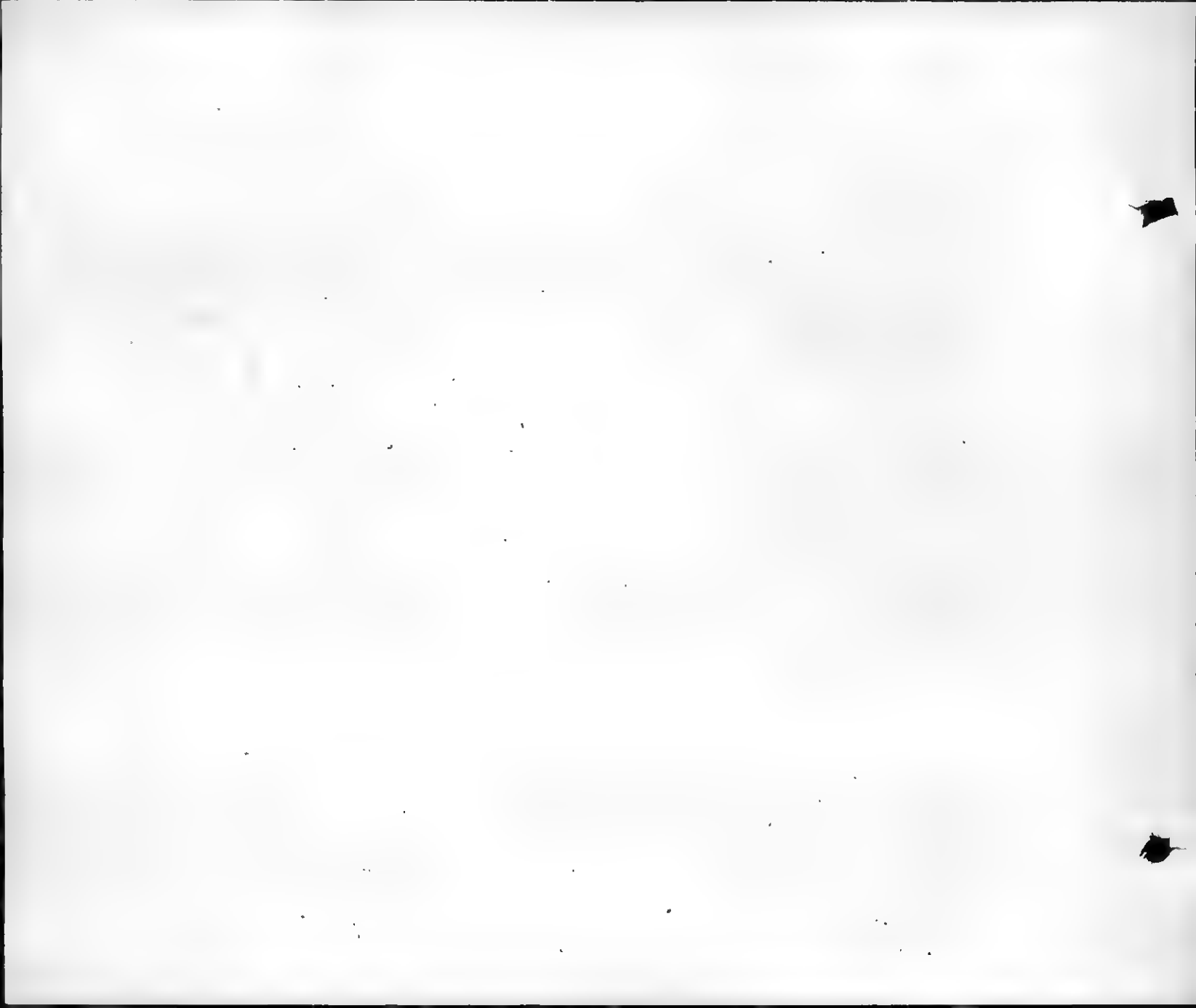
14100

## CERTIFICATE OF DEATH

Reg. Dist. No. 13984

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AQUASCO</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X AQUASCO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA</u> <u>BERRY</u>				4. DATE OF DEATH Month Day Year <u>Dec.</u> <u>30</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u>	9. AGE (in years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>—</u>				14. MOTHER'S MAIDEN NAME <u>Bettie Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Walter Berry Aquasco md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Generalized coronary-vascular disease</u> DUE TO (c) <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-16</u> 19 <u>56</u> , to <u>12-30</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12-10</u> 19 <u>57</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>—</u> <u>12-31-57</u>							
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.				SIGNATURE <u>Bradywine</u> <u>md.</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson, M.D. Bradywine, md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Phillips Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aquasco md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Nelson</u>				ADDRESS <u>Aquasco md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



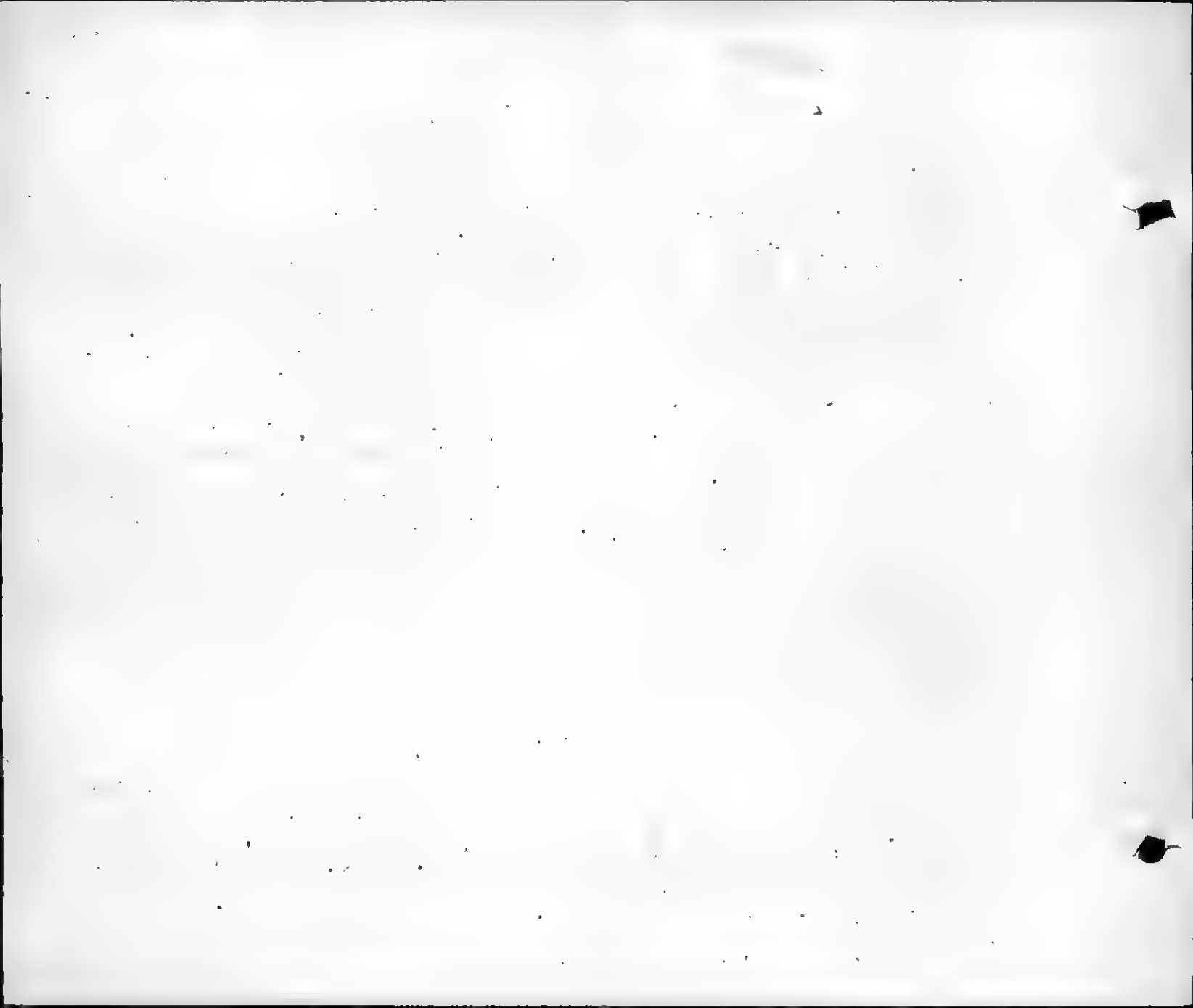


14026

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 6 w. 10 mo. 20 da Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel Sanitarium		d. STREET ADDRESS 1431 Linden Ave.	
3 NAME OF DECEASED (Type or print) Margaret C. Betticher		4 DATE OF DEATH Dec - 31 1959	
5. SEX 7	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2. 1877
9 AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Richmond Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Baker Graves		14. MOTHER'S MAIDEN NAME Emily Wight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 518-10-10000	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week 6 1/2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11/53, 19, to 12-31-1959, that I last saw the deceased alive on 12-31-1959, and that death occurred on 12-31-1959, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jesse C. Coggins M.D.		ADDRESS (Street, city or town, state) 12-31/59 DATE SIGNED	
PHYSICIAN'S NAME (Type) Jesse C. Coggins, M.D. Laurel Sanitarium		PHYSICIAN'S NAME (Type) Jesse C. Coggins, M.D. Laurel - Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-4-1960	
22c. NAME OF CEMETERY OR CREMATORY ST. THOMAS		22d. LOCATION (City, town, or county) (State) GARRISON FOREST MD	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins, Son Co. 4905 York Rd.		24a. REC'D BY REGISTRAR JAN 5 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13987

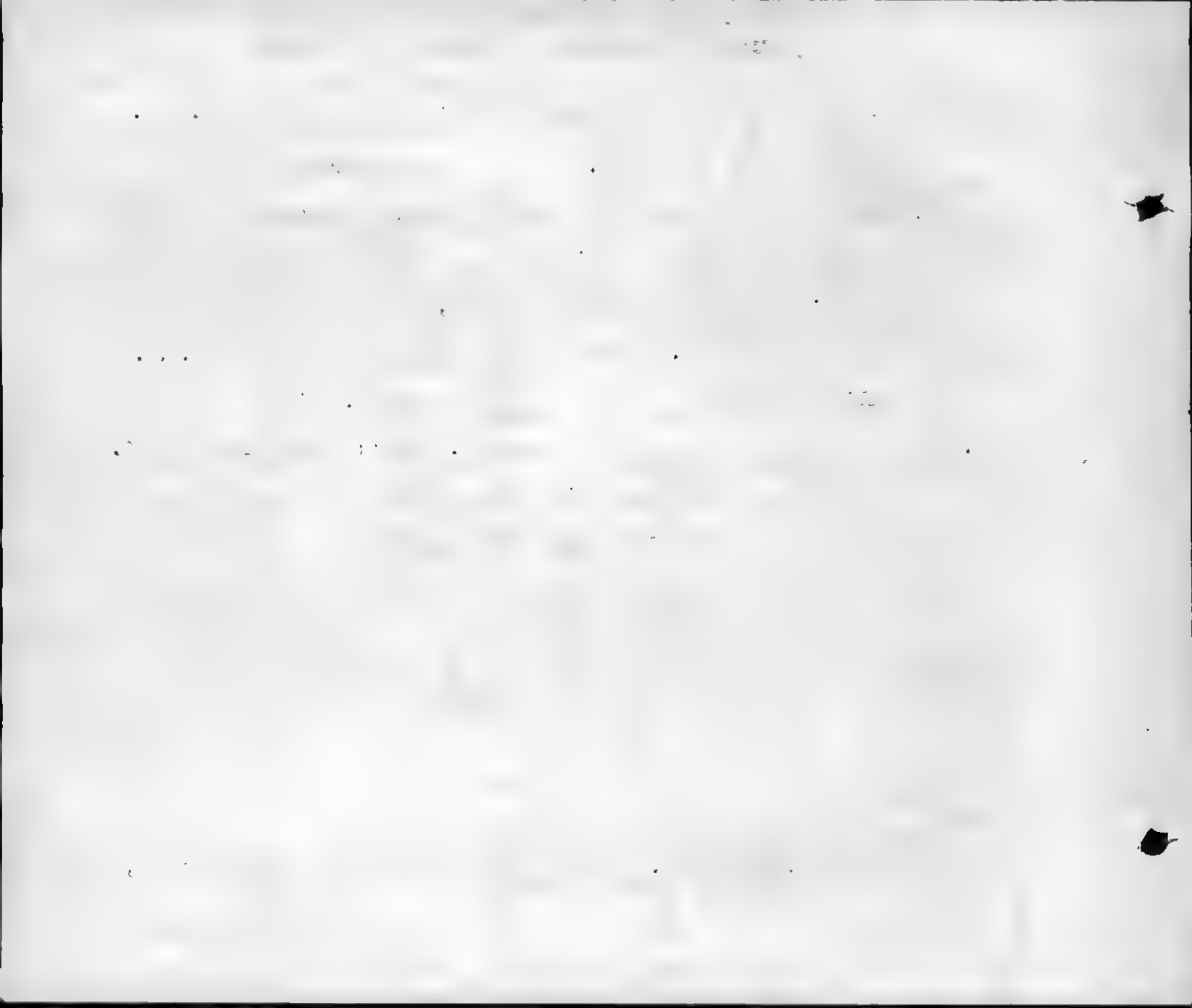
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmer Park</b>			c. LENGTH OF STAY IN 1b <b>3 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmer Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7413 84th Place</b>				d. STREET ADDRESS <b>7413 84th Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Ferdinand</b> Last <b>Biggs</b>				4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>May 20, 1877</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired screenman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Biggs</b>				14. MOTHER'S MAIDEN NAME <b>Mary V. King</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>No.</b>		17. INFORMANT Address <b>Walter L. Purvis; same address as # 2.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec 28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Bros</b>				23b. ADDRESS <b>166194 Hager Rd SE</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Edward S. Hall</b>				24c. DATE SIGNED <b>December 25, 1959</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

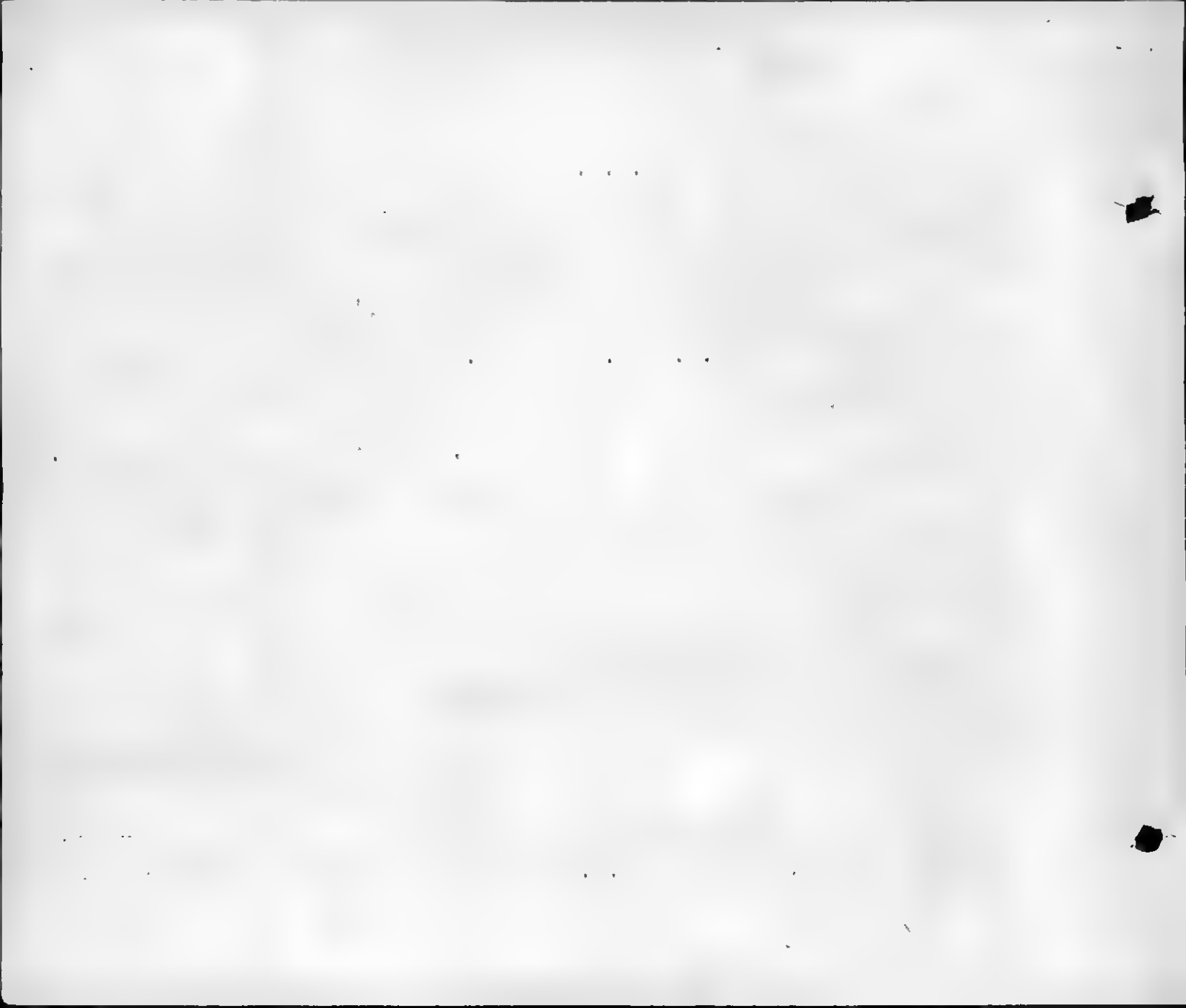
13987

Reg. Dist. No.

14027

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>3416 N. Glebe Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>			
3. NAME OF DECEASED (Type or print) <b>Sidney Fay Blake</b>		4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, '92</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. UNDER 1 YEAR Months <b>6</b> Days <b>7</b>	11. UNDER 24 HRS. Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Botanist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Dept. of Agric.</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter R. Blake</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Southworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Doris H. Blake; same address as # 2.</b>	
17. INFORMANT <b>Doris H. Blake; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>400.1</b> DUE TO (b) <b>Ventricular fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>12-31-59</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/2/60</b>	22b. DATE THEREOF <b>1/2/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph S. Smith, Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 4 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

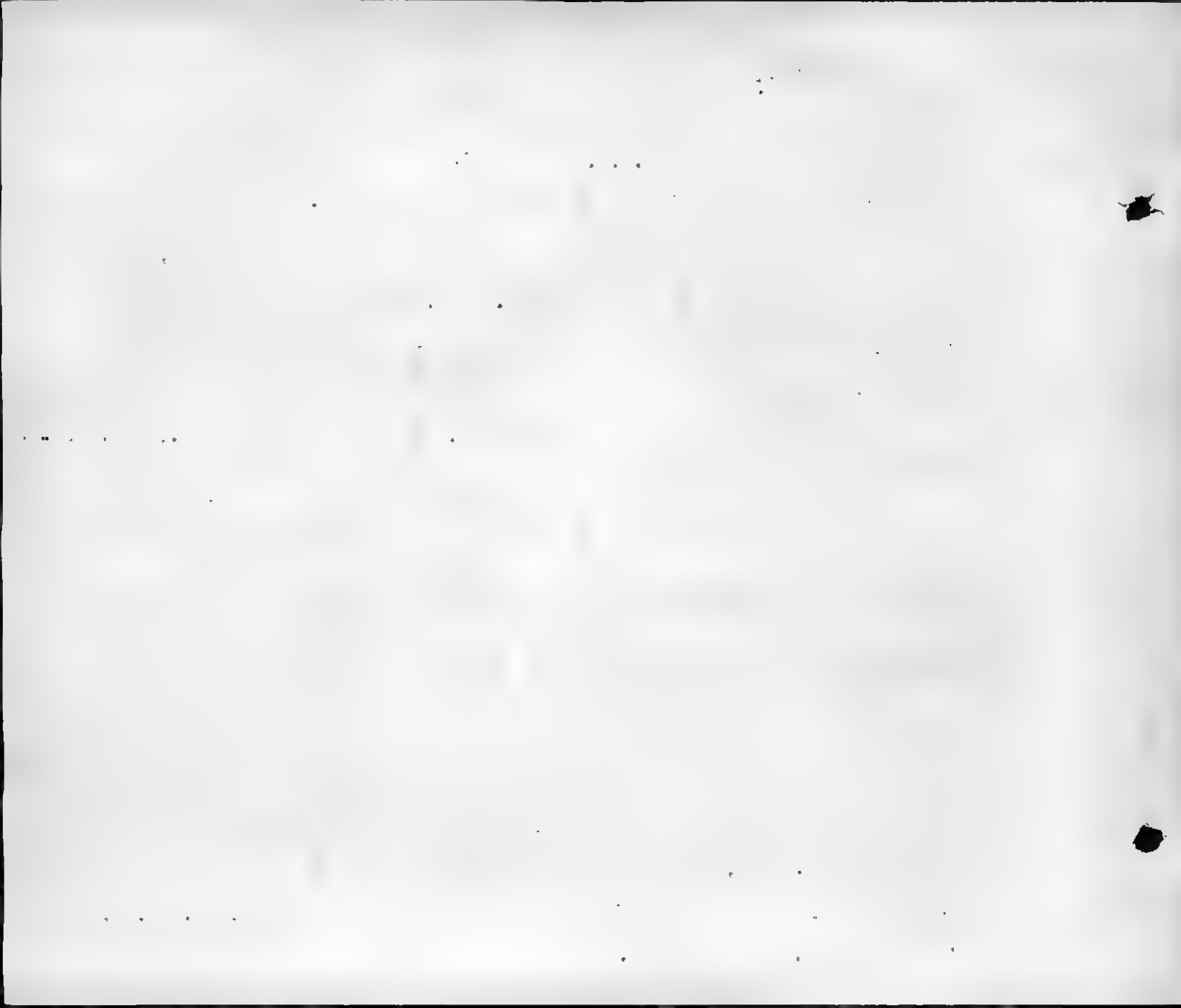
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14028

Reg. Dist. No. 13988

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If out of corporate limits, write R.U.P.A. and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Distriot Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>7407 Gateway Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>ZENA</b> Middle <b>MARY</b> Last <b>BORZI</b>		4. DATE OF DEATH Month <b>December</b> Day <b>14th</b> , Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14th, 1893</b>
9. AGE (in years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailoress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Sambataro</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Carmelo E. Borzi, 2420 Iverson St., Wash. 21, D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary thrombosis</b> (c) <b>Cardiovascular renal disease</b> cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 17, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b> ADDRESS <b>Co., Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14009

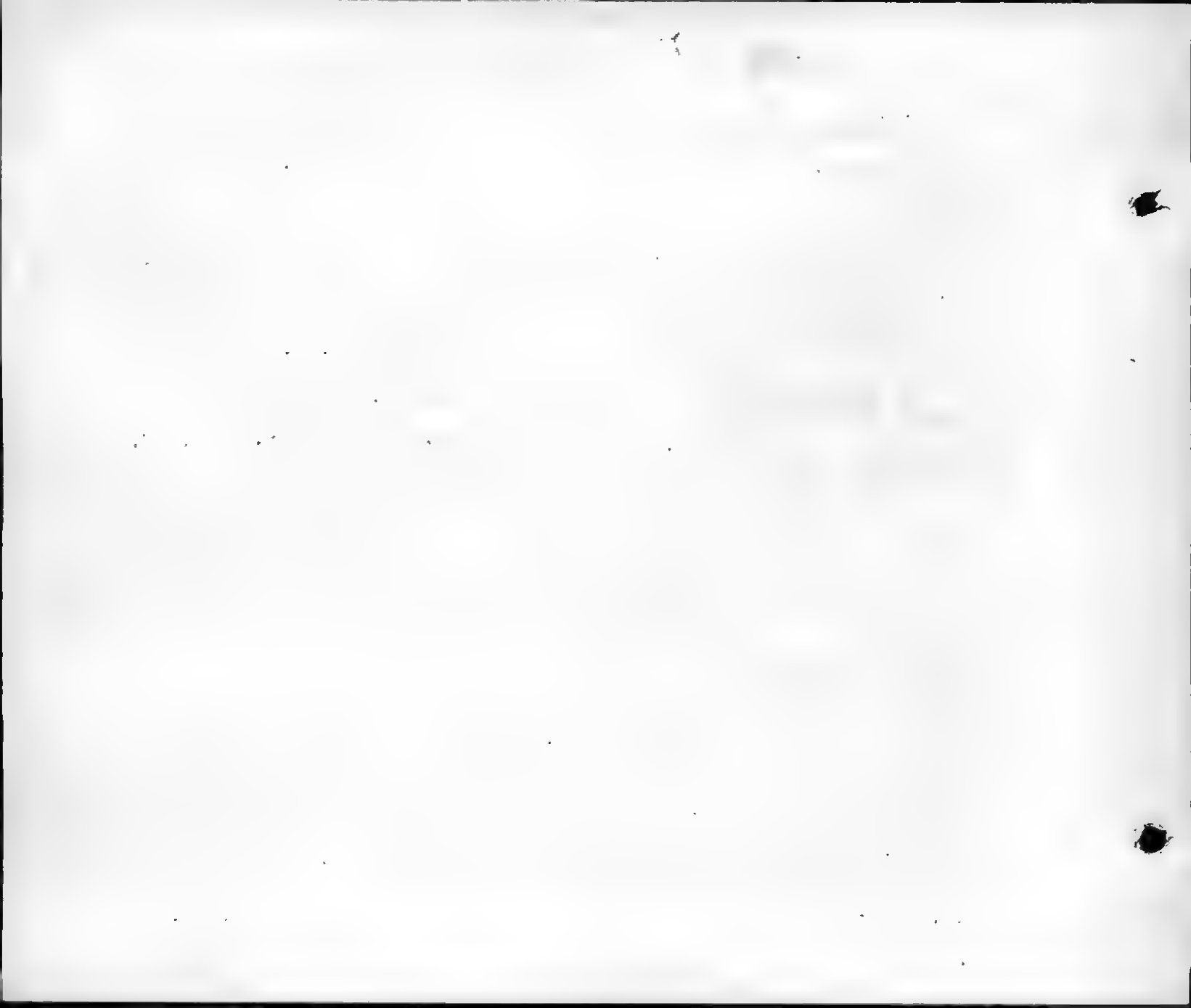
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md.</b>		c. LENGTH OF STAY IN 1b <b>40 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4111 Gallatin St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marvette</b> Middle <b>Vanessa</b> Last <b>Boswell</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>16</b> Year <b>19 59-</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16, 1889</b>
9. AGE (In years last birthday) <b>70 yrs</b>		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John James Bowler</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Loriner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>	
17. INFORMANT <b>Harry A. Boswell</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lupus Erythematosus</b> <b>5.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Lupus +</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <b>1-9</b> , 19 <b>59</b> , to <b>12-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-16</b> , 19 <b>59</b> , and that death occurred at <b>6:40 P.M.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Waldo B. Moyers</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 Perry St</b> DATE SIGNED <b>12-17-59</b>	
PHYSICIAN'S NAME (Type) <b>Waldo B. Moyers</b>		<b>Mt. Rainier Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 19, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Anthony P. Kraus</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

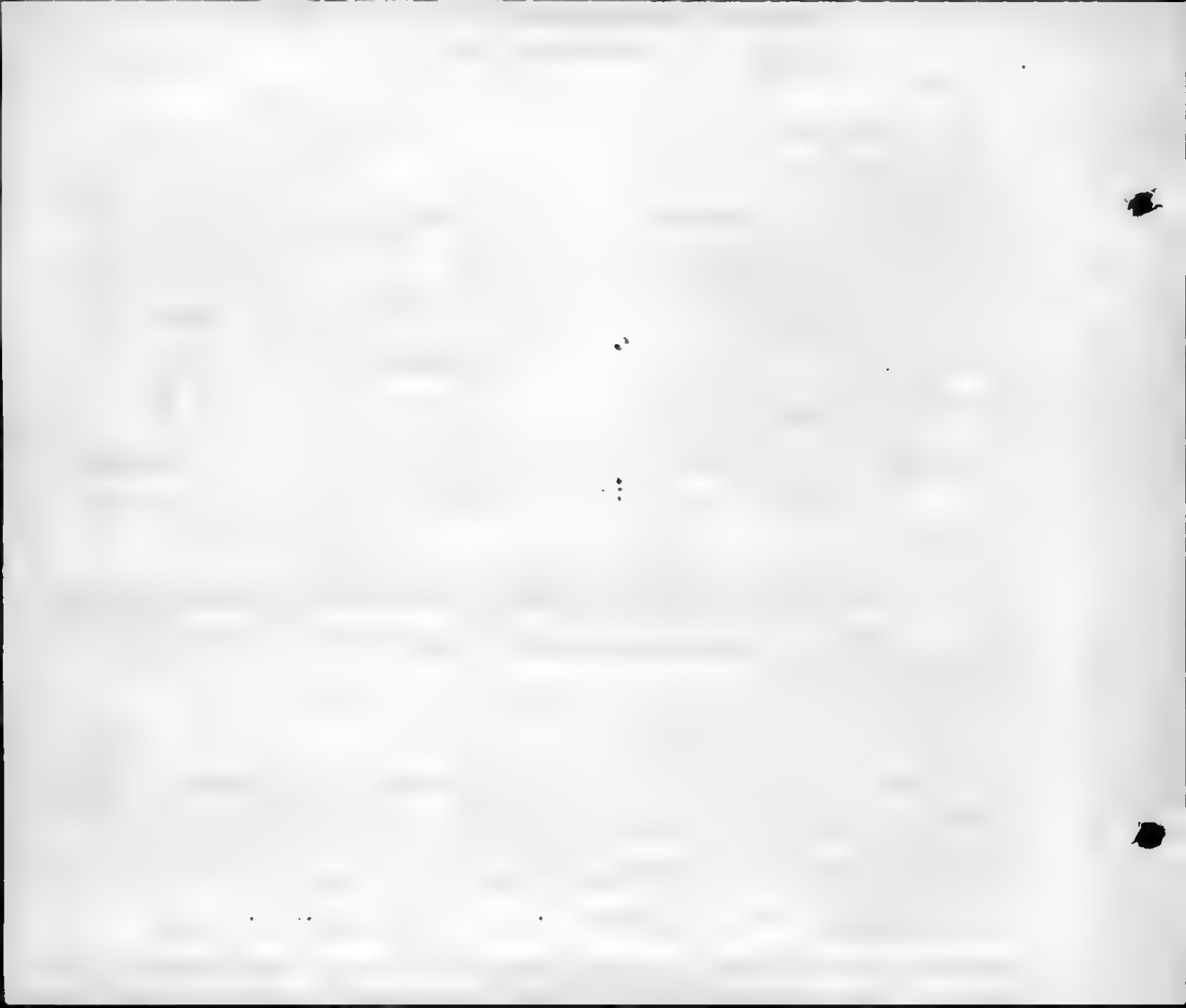
14029

## CERTIFICATE OF DEATH

Reg. Dist. No.

13990

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Co. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
c. LENGTH OF STAY IN 1b <u>11 mo. less 1 day</u>		d. STREET ADDRESS <u>248 Rogers Forge Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Irma</u> Middle <u>D.</u> Last <u>Burton</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21-1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel C. Appleby</u>		14. MOTHER'S MAIDEN NAME <u>Clara T. Irving</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>(Son) 1217 Southdown Rd. S. Dixon Burton - Hillsborough - California</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerosis - Cerebral</u> DUE TO (c) <u>Cerebral hemorrhages</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 7.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 10</u> , 19 <u>59</u> , to <u>Dec. 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 8</u> , 19 <u>59</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u>		ADDRESS (Street, city or town, state) <u>M.D. Laurel Sanitarium - Laurel-Md</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Coggins M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lusk</u>		24a. REGISTERED BY REGISTRAR <u>DEC 10 '59</u>	
ADDRESS <u>10101 Towsen</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14030

CERTIFICATE OF DEATH

Reg. Dist. No.

13931

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville	
c. LENGTH OF STAY IN TB 3 hours		d. STREET ADDRESS 14520 Columbia Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital, Inc.		e. IS RESIDENCE ON A FIRM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DEANER Middle CARR Last		4. DATE OF DEATH Month December 10 Year 1959	
5. SEX male	6. COLOR OR RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 11 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General construction - Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander B Carr		14. MOTHER'S MAIDEN NAME Mame U Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213 N 2177	
17. INFORMANT Mrs Susan Carr		Address Burtonsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, posterior, acute DUE TO (b) Arteriosclerotic heart Disease (c) Diabetes mellitus, with acute diabetic acidosis, without coma INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) No injury		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 PM 10 Dec. 1959, to 5:45 PM 10 Dec 59 that I last saw the deceased alive on 10 December 1959, and that death occurred at 5:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard Compton M.D.		ADDRESS (Street, city or town, state) 612 Main Street, Laurel, Maryland	
DATE SIGNED 10 Dec 59			
PHYSICIAN'S NAME (Type) J. Richard Compton, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/59	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Burtonsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE DEC 17 '59		C. S. H. HARRIS	



## CERTIFICATE OF DEATH

Reg. Dist. No.

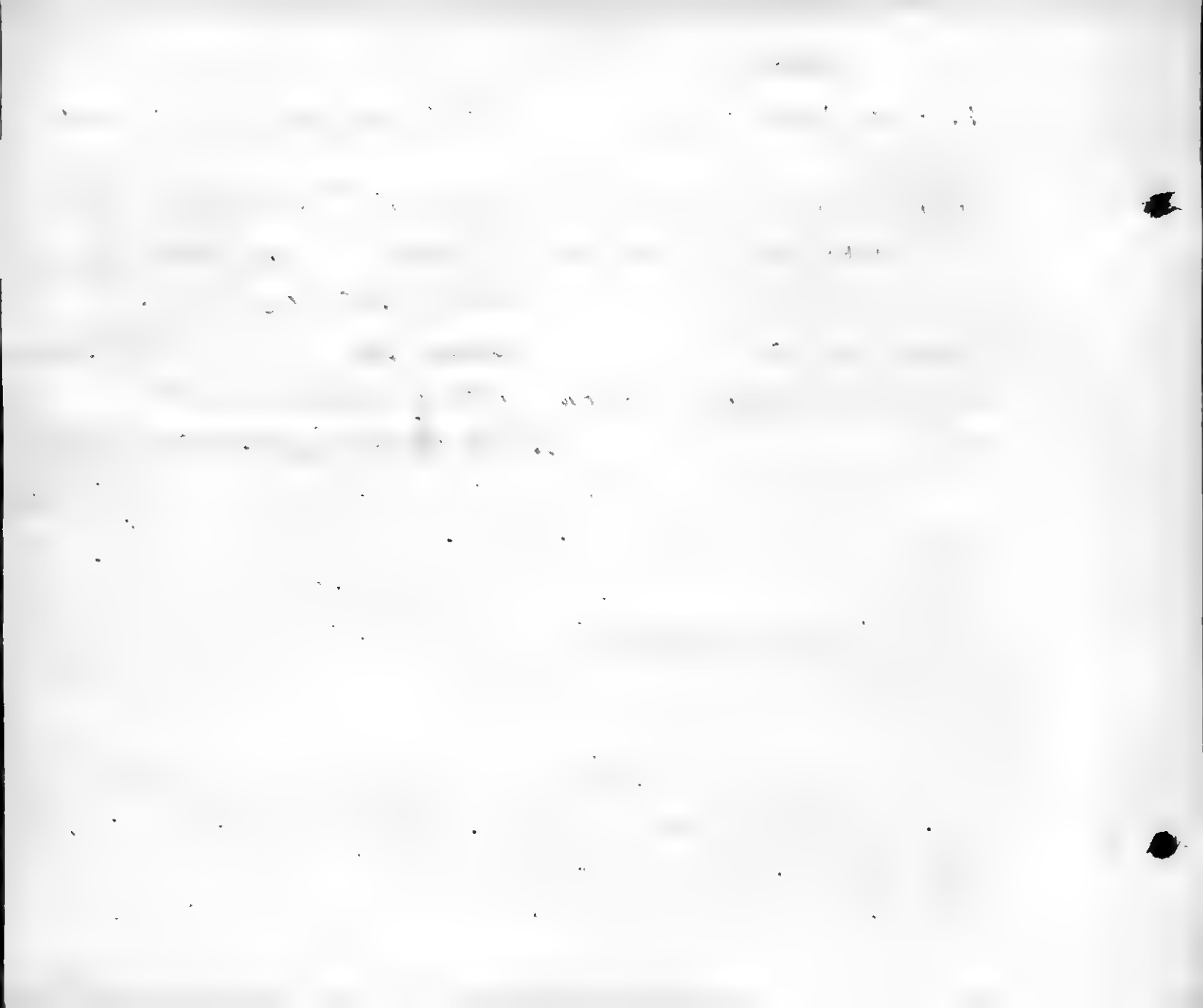
13992

14010

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) o. STATE <u>WASH.</u> b. COUNTY <u>DISTRICT OF COLUMBIA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 LASHALL RD</u>				d. STREET ADDRESS <u>4365-13th Street N.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>VIRGINIA</u> Last <u>CARR</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 26, 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>30</u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. DC</u>		11. BIRTHPLACE (State or foreign country) <u>United States</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>JAMES SPENCER JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANNE POORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Sister Agnes Patricia 4922 Lashall Rd.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 220X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis, general</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis, spine, hips, knees</u> INTERVAL BETWEEN ONSET AND DEATH <u>2.5 hours</u> <u>Years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 10, 1959</u> to <u>Dec 15, 1959</u> that I last saw the deceased alive on <u>Dec 14, 1959</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Brennan Jr.</u>				DATE SIGNED <u>12/15/59</u>			
PHYSICIAN'S NAME (Type) <u>JOHN F. BRENNAN JR. M.D.</u>				ADDRESS (Street, city or town, state) <u>1034 PERRY ST., N.E. WASH. 17, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>dec 18, 1959</u>		<u>St. Mary's</u>		<u>Washington DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Luffell, 475 2nd St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>			
ADDRESS <u>Washington, DC</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur B. Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

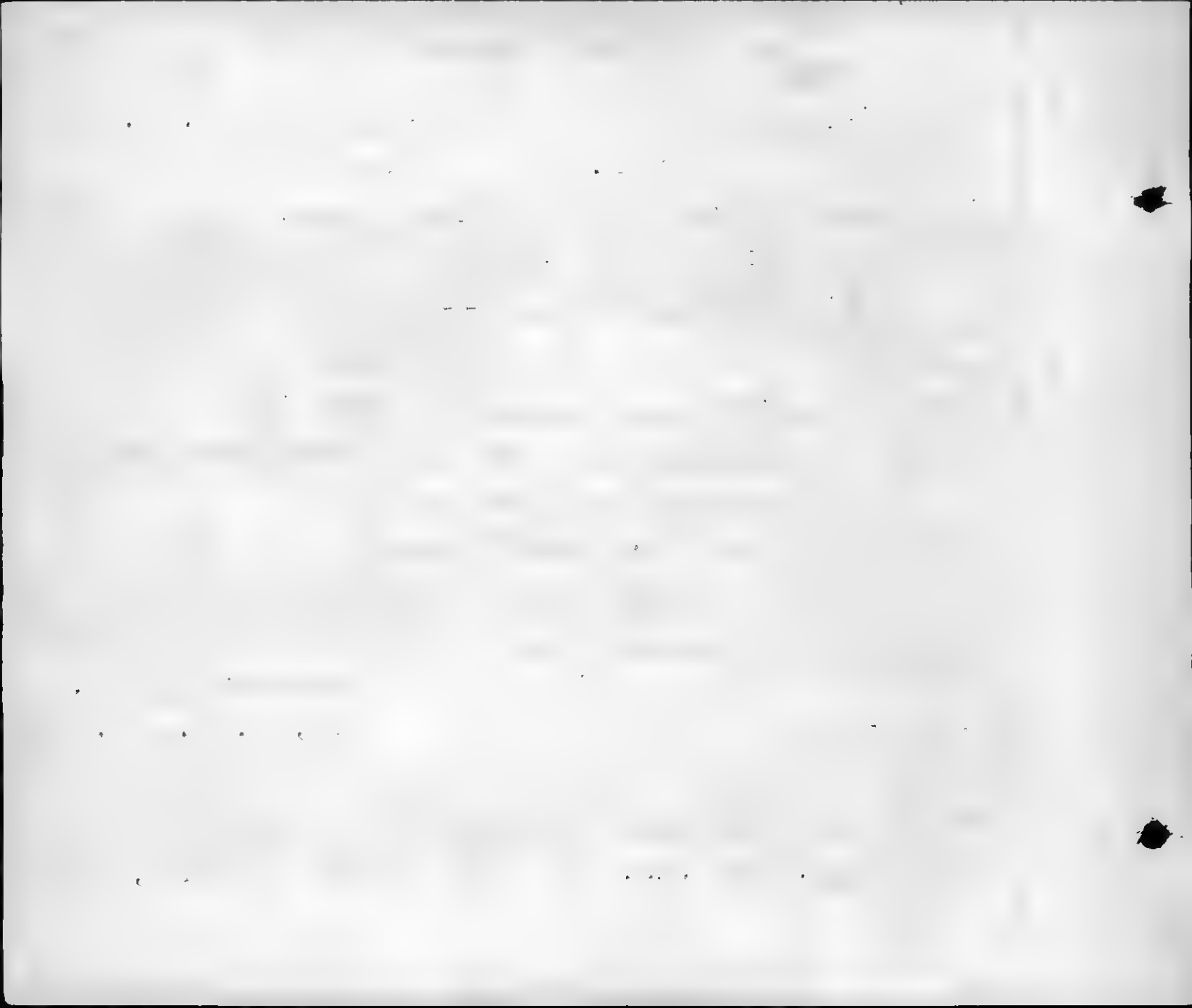
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 13993									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b 2 1/2 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital					d. STREET ADDRESS 352 Main Street				
3. NAME OF DECEASED (Type or print) First Middle Last Michael Chung					4. DATE OF DEATH Month Day Year December 15 19 59				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-53		9. AGE (In years last birthday) 6 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cooley Yee Chung					14. MOTHER'S MAIDEN NAME Theadora Shiff				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Cooley Yee Chung; same address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma, multiple and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) returning home from school Struck by a truck while playing in the street in Laurel, Md.						
20c. TIME OF INJURY Month, Day, Year 2:45 p.m. 12-15-59 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Laurel, Pr. Geo. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney					DATE SIGNED December 15, 1959				
EXAMINER'S NAME (Type) John T. Maloney, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Hall Cem			22d. LOCATION (City, town, or county) (State) Arlington Va		
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson, Laurel, Md					24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REG. STRAR'S SIGNATURE Arthur S. Frank		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13. See: Birth Cert. et

## CERTIFICATE OF DEATH

Reg. Dist. No.

13994

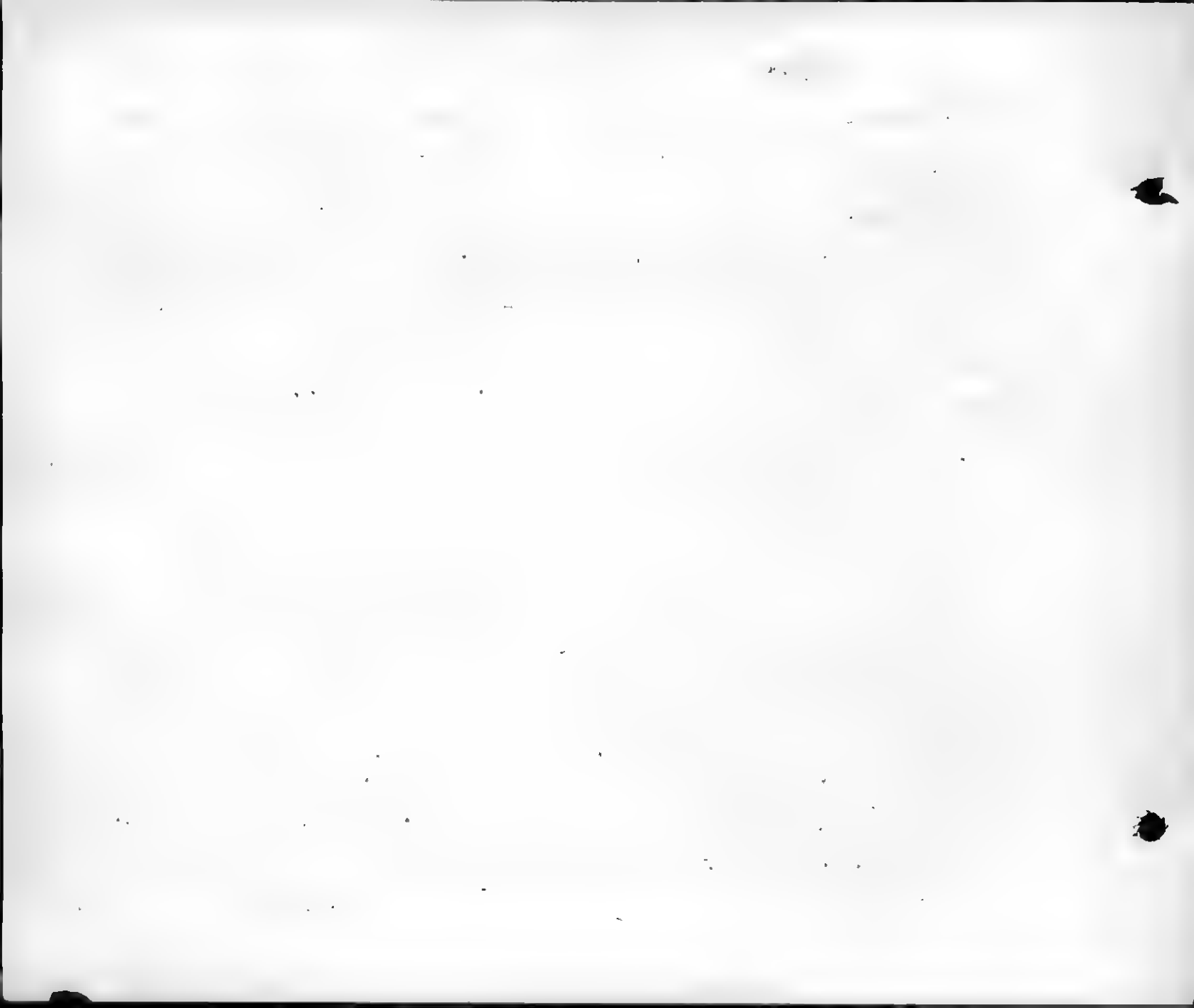
14032

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>54 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b> d. STREET ADDRESS <b>6401 Walker Mill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Tangela Della Colbert</b>				4. DATE OF DEATH Month Day Year <b>December 29 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-6-59</b>	
9. AGE (in years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min <b>1 23</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Cheverly, Maryland</b>	
10a.		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Sterling Alvin Colbert</b>				14. MOTHER'S MAIDEN NAME <b>Theresa Proctor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonitis</b> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cleft Palate</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 25 19 59</b> to <b>Dec. 29 19 59</b> , that I last saw the deceased alive on <b>Dec. 29 19 59</b> , and that death occurred at <b>4:30 PM</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>3001 Cheverly Ave, Cheverly Md</b> DATE SIGNED ACTUAL SIGNATURE <b>Dr. B. Van Gelderan</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. B. Van Gelderan</b>							
22a. BURIAL, CREMATION, REINMENT (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>12/31/1959</b>		<b>Int alivet</b>		<b>Washington</b>		<b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. E. THOMAS</b> ADDRESS <b>2500 Nichols Ave SE</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hearn</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077152XV4





1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

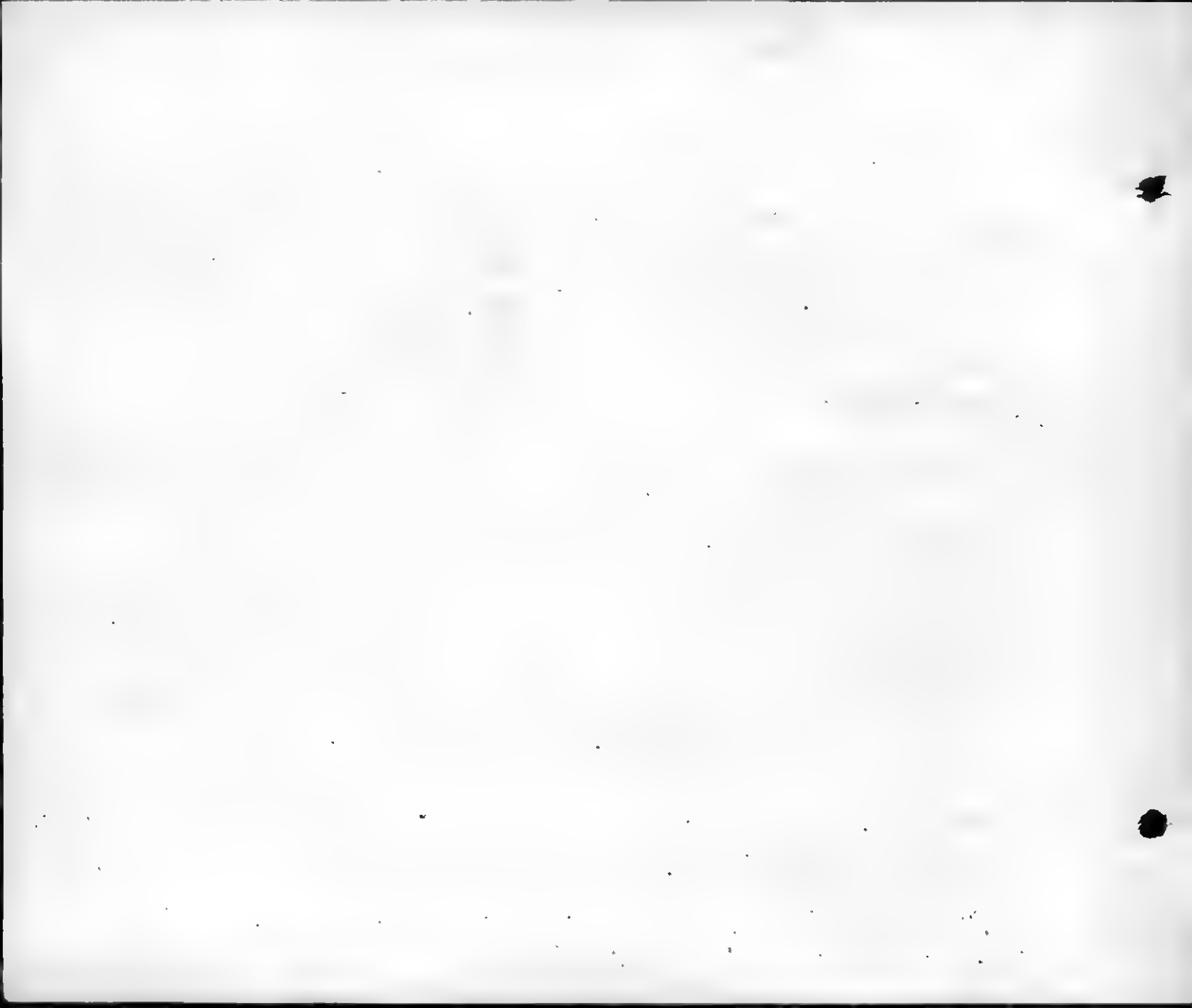
14033

CERTIFICATE OF DEATH

Reg. Dist. No.

13995

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Hyattsville	
c. LENGTH OF STAY IN 1b 9 Hours		d. STREET ADDRESS 5354 Quincy Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby		4. DATE OF DEATH December 20 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11:10 AM Dec. 20/1959	
9. AGE (In years lost birthday) yrs. 9		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Compton		14. MOTHER'S MAIDEN NAME Patricia Imogene Cantwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Meningocele DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Congenital	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-20, 1959, to 12-20, 1959, that I last saw the deceased alive on 12-20, 1959, and that death occurred at 8:20 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. D. BAKER M.D.		ADDRESS (Street, city or town, state) M.D. 2513 Buck Lodge Rd. DATE SIGNED 12-21-59	
PHYSICIAN'S NAME (Type) R. D. BAKER, M.D.		Hdelpi md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12/21/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14034

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13997

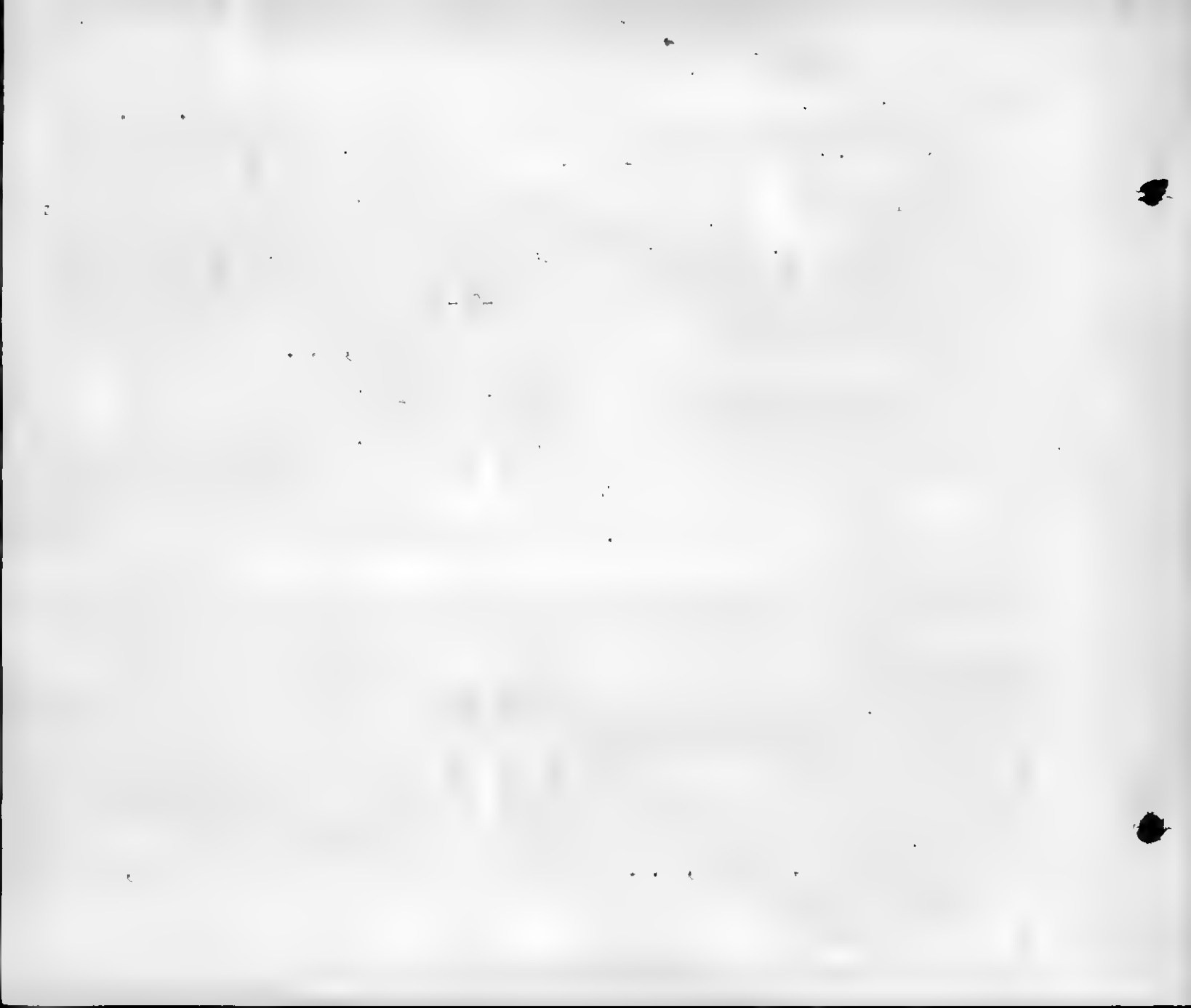
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Georges General Hospital DOA</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cheverly</b>				d. STREET ADDRESS <b>5304 Gallatin Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Gaines</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-58</b>	9. AGE (in years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Henry Stone</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Canning</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marguerite Davis; same address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c), stating the underlying cause lost. DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



14035

## CERTIFICATE OF DEATH

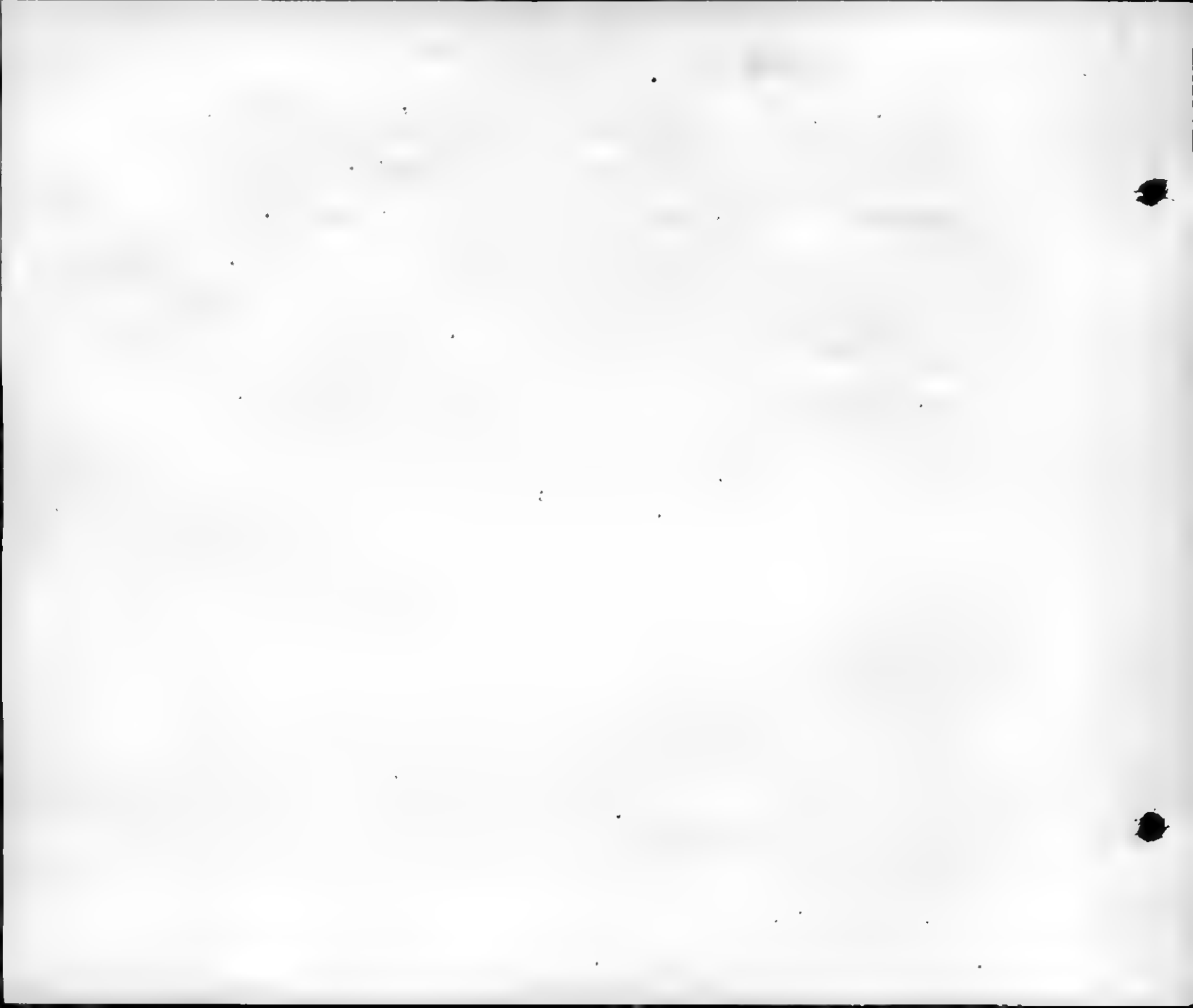
Reg. Dist. No.

13998

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>14 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 22</b> d. STREET ADDRESS <b>6852 Allentown Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter B. Defibaugh</b>		4. DATE OF DEATH Month Day Year <b>Dec. 16 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 June 1959</b>
9. AGE (In years last birthday) <b>5 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>5</b>	11. IF UNDER 24 HRS Months Days Hours Min. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Walter Defibaugh</b>		14. MOTHER'S MAIDEN NAME <b>Delores Ann Ballengee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Cheverly Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>acute myocardial infarction with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>abscoro pneumonia, bilateral</b> (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Saturday</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur S. Gasch</b> M.D.		ADDRESS (Street, city or town, state) <b>3001 Cheverly Ave, Cheverly, Md.</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rhoates Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Saxton Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Gasch</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14036

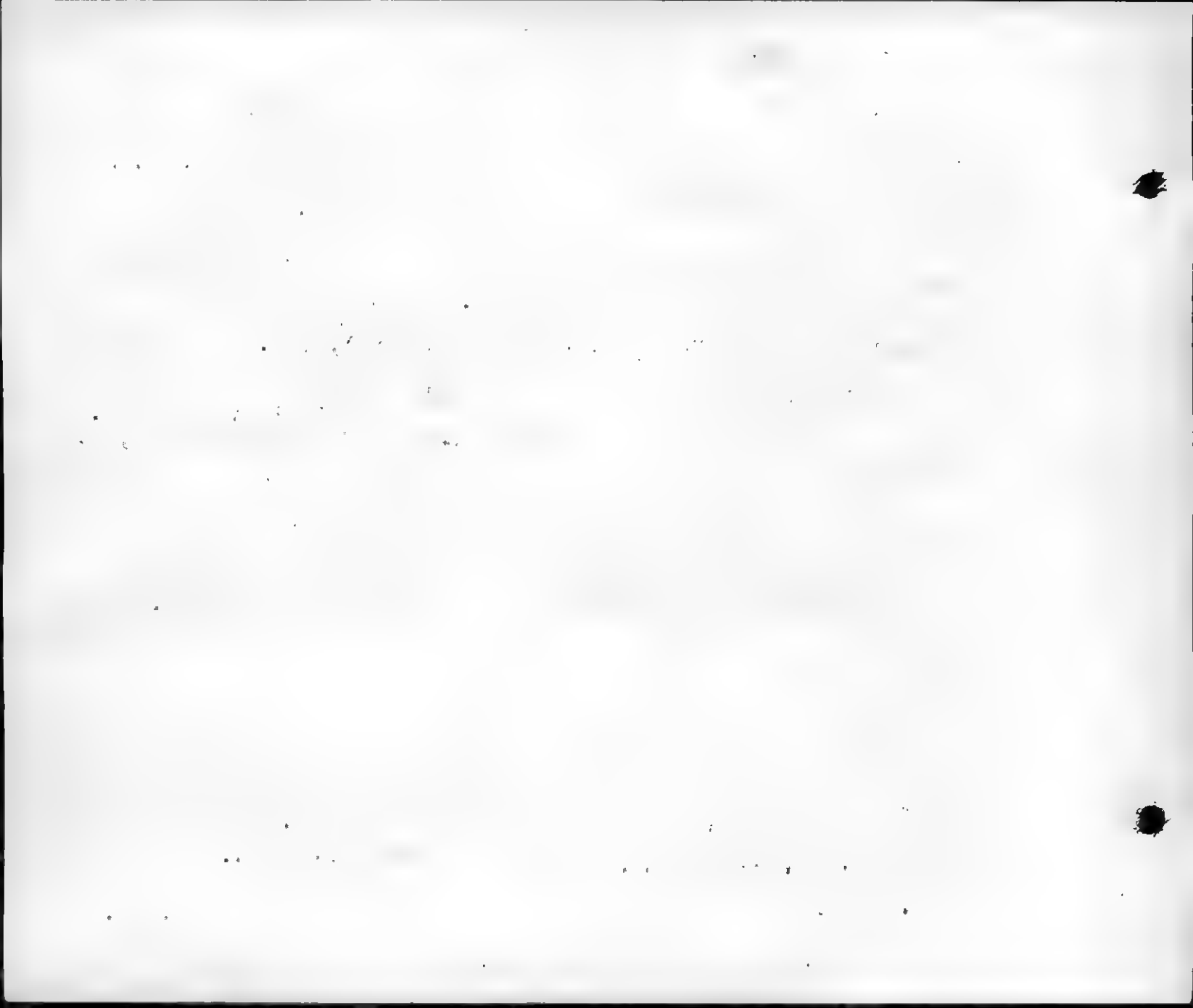
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>C</b> Last <b>Denn</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 4, 1881</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>	11. IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Painting</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mart Denn</b>		14. MOTHER'S MAIDEN NAME <b>Mary Grisby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Thelma N. Heffner</b>		6201 Rollins Ave. <b>Seat Pleasant, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 443x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypertensive Cerebro-vascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov - 15, 1949</b> to <b>Dec. 17, 1959</b> , that I last saw the deceased alive on <b>12-17-59</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thelma N. Herzberg</b>		ADDRESS (Street, city or town, state) <b>7016 Greig St. Seat Pleasant, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Max. Herzberg, M.D.</b>		DATE SIGNED <b>DEC 21 '59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		24a. REC'D BY REGISTRAR <b>517 11th St. SE</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>DEC 21 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

14010

14011

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN 1b <i>8 mos 4 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Miss Bell's Nursing Home</i>				e. STREET ADDRESS <i>7215 Elmhurst St</i>			
3. NAME OF DECEASED (Type or print) <i>Michael Timothy Drass</i>				4. DATE OF DEATH Month <i>12</i> Day <i>29</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/25/1958</i>		9. AGE (In years lost birthday) <i>1</i> yrs.	IF UNDER 1 YEAR Months <i>10</i> Days <i>4</i>	IF UNDER 24 HRS Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John E. Drass</i>				14. MOTHER'S MAIDEN NAME <i>Theresa Harlow</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Theresa Drass</i> Address <i>same as X. 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hydrocephalus (internal)</i> 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>birth on</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/25</i> , 19 <i>59</i> , to <i>12/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/29</i> , 19 <i>59</i> , and that death occurred at <i>4:10</i> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Thomas A. Christensen</i> M.D.				ADDRESS (Street, city or town, state) <i>6905 Balch Rd College Park, Md</i>			
PHYSICIAN'S NAME (Type) <i>Thomas A. Christensen</i>				DATE SIGNED <i>12/29/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-30-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Food</i>		22d. LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. G. Matherly</i> ADDRESS <i>131-17th St. S.E.</i>				24a. REC'D BY REGISTRAR <i>DEC 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14037

CERTIFICATE OF DEATH

Reg. Dist. No.

14001

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>9 days (Hosp.)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EUGENE LELAND MEMORIAL Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>G.</u> Middle <u>DUNWOODY</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 6 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Fleet</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Garnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia + Pericarditis</u> DUE TO (b) <u>Bile Peritonitis + L. Subphrenic Abscess</u> DUE TO (c) <u>Cholelithiasis + Obstruction of Sphincter of Oddi</u> 10 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Parotitis on Rt</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 15, 1959</u> to <u>Dec. 18, 1959</u> that I last saw the deceased alive on <u>Dec. 18, 1959</u> and that death occurred at <u>11:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rowland E. Wilkinson</u> M.D.		ADDRESS (Street, city or town, state) <u>4404 Queensbury Road</u> DATE SIGNED <u>12-19-59</u>	
PHYSICIAN'S NAME (Type) <u>Rowland E. Wilkinson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brimington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brimington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel B...</u> ADDRESS <u>1641-9d Nape Rd 2-Z.</u>		24a. REC'D BY REGISTRAR <u>DEC 22 1959</u> 24b. REGISTRAR'S SIGNATURE <u>...</u>	



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THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

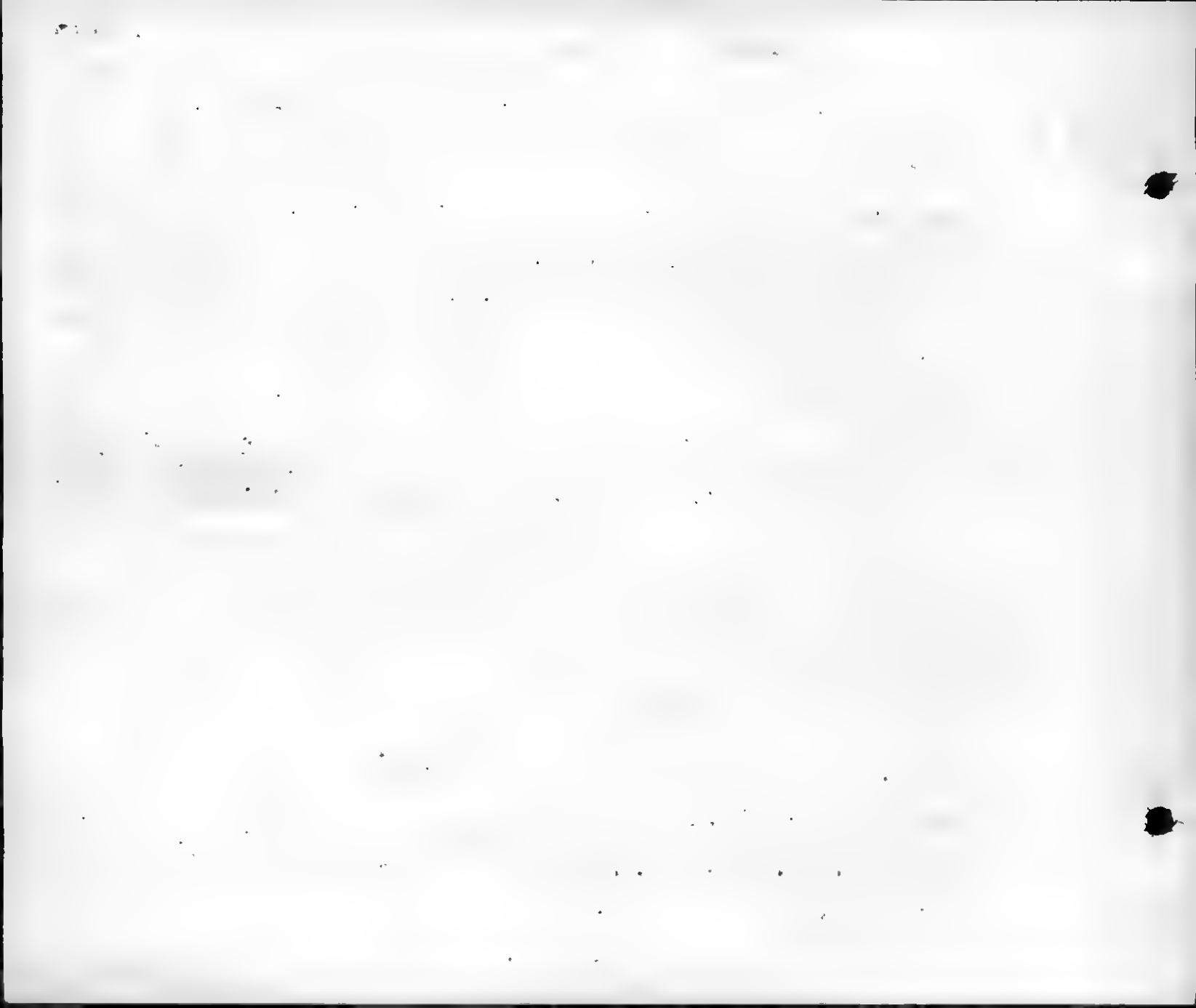
14902

14038

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 Hr</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>3833 Bladensburg Rd</b>							
NAME OF DECEASED (Type or print) <b>George Paul Sr. Duvall</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 11, 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>18</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS Months <b>6</b> Days <b>18</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bar Tender</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John W Duvall</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>213 16 244A</b>			
17. INFORMANT <b>Ann L Duvall</b>				Address <b>Colmar Manor Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Bacterial pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Interval between onset and death</b> (c) <b>1 week</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus. Generalized atherosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Colmar Manor</b>				(County) (State)			
21. I certify that I attended the deceased from <b>12-13</b> , 19 <b>59</b> , to <b>Dec. 18</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec. 16</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George Hageage</b>				ADDRESS (Street, city or town, state) <b>3717-38th Ave Cottage City, Md</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Geo. Hageage, M.D.</b>				DATE SIGNED <b>12-18-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wheaton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

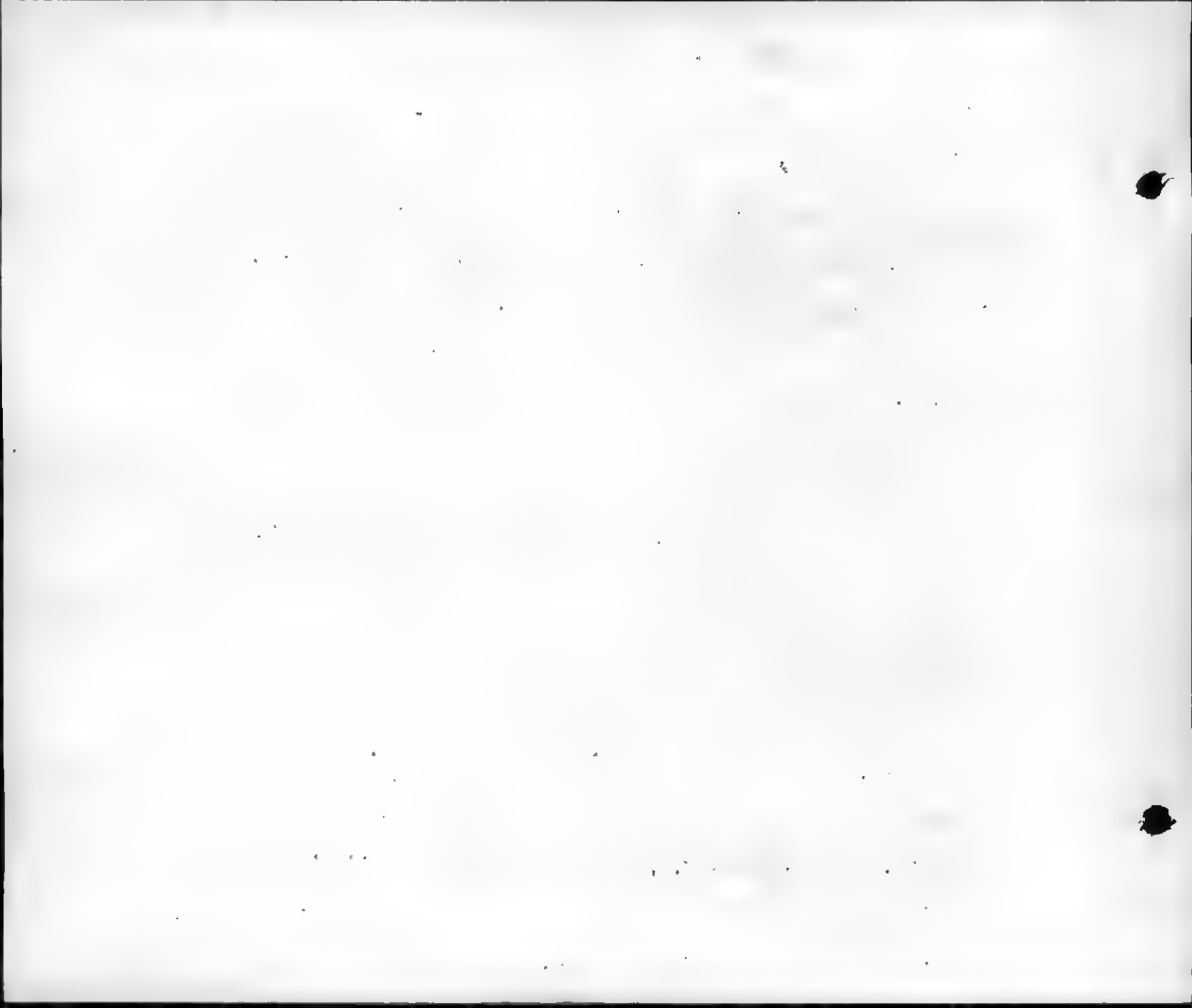
14039

CERTIFICATE OF DEATH

Reg. Dist. No.

14003

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		2. USUAL RESIDENCE (Where deceased lived If instit. an. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Lanham Hills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>						e. STREET ADDRESS <b>7726 Emerson Road</b>			
3. NAME OF DECEASED (Type or print) First: <b>Dyer</b> Middle: <b>Regina</b> Last: <b>Dyer</b>						4. DATE OF DEATH Month: <b>Dec.</b> Day: <b>25</b> Year: <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 8, 1959</b>		9. AGE (In years last birthday) <b>6 Weeks</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>James R. Dyer</b>						14. MOTHER'S MAIDEN NAME <b>Sandra Ripka</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT <b>Father James R Dyer West Lanham Hills Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Murder</b> <b>756.0</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hyper trophic pylorostenosis</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street office bldg., etc.)		20f. (City or town) <b>Cottage City, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Nov. 8, 1959</b> , to <b>Dec. 25, 1959</b> that I last saw the deceased alive on <b>Dec. 24, 1959</b> , and that death occurred at <b>7:30AM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>George Hageage</b>		M.D. <b>3717-38th Ave</b>		ADDRESS (Street, city or town, state) <b>Cottage City, Md.</b>		DATE SIGNED <b>12-59</b>			
PHYSICIAN'S NAME (Type or print) <b>Dr. George Hageage, M.D.</b>									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 28, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	





1  
 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

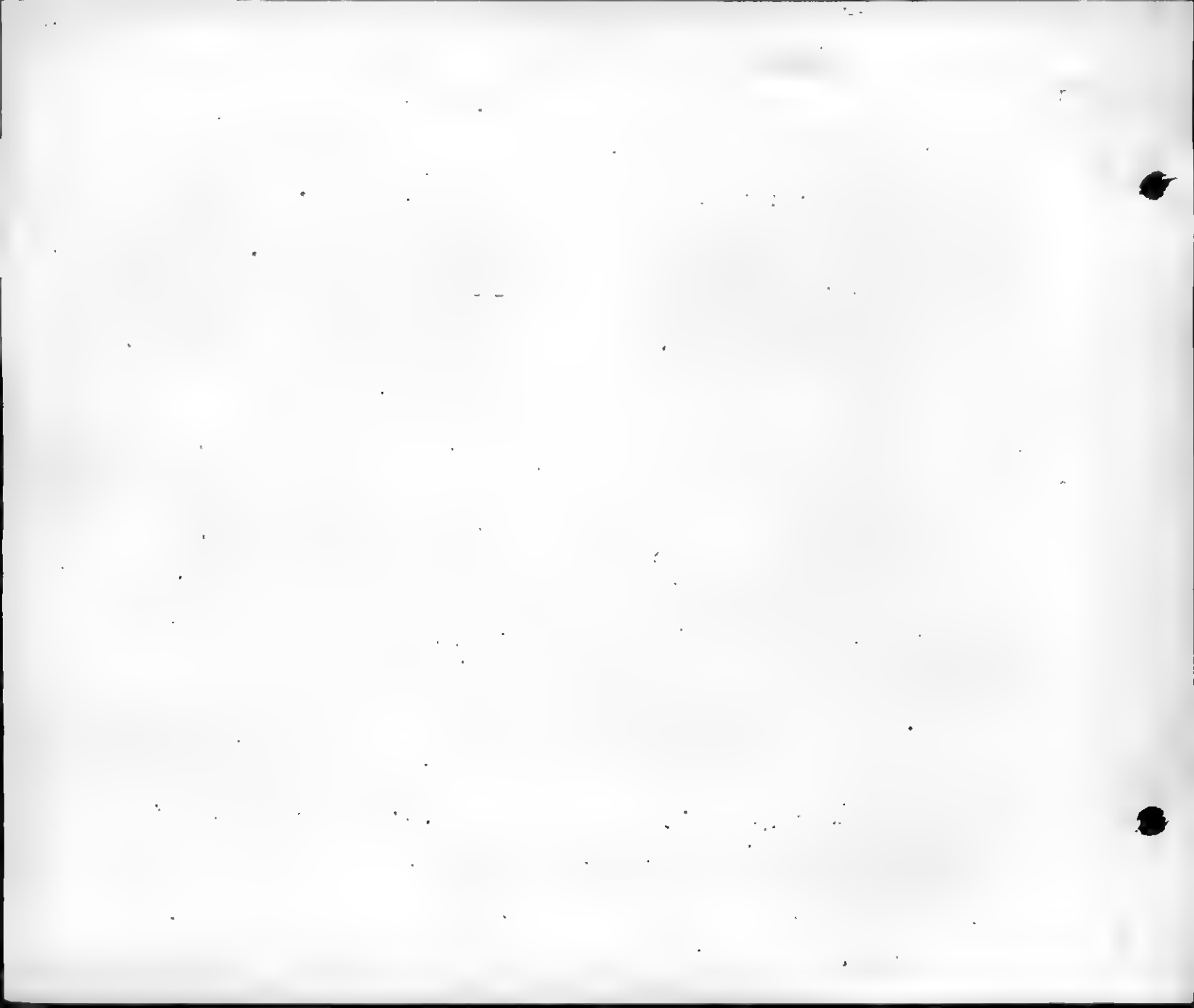
14004

14040

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. <b>Maryland</b> b. COUNTY <b>Prince George</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		d. STREET ADDRESS <b>3005 Cheverly Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Frederick Dyson</b>		4. DATE OF DEATH Month Day Year <b>Dec. 1 19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-4-86</b>		9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postal Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Employee</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>		13. FATHER'S NAME <b>William W Dyson</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Moran</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Vivian Huntley Cheverly, Md.</b>					
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>610X Cardiac failure</b> DUE TO (b) <b>Uremia &amp; Renal Insufficiency</b> DUE TO (c) <b>Chronic Benign Prostatic Hypertrophy</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>11/59</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholecystectomy; Pancreatotomy for CA in 1949</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>10:30 Dec. 1 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11/13</b> , 19 <b>59</b> , to <b>12/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/30</b> , 19 <b>59</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.		ADDRESS (street, city or town, state) <b>6300 Riverdale Rd</b>		DATE SIGNED <b>William A. Stecher</b>		ACTUAL SIGNATURE <b>William A. Stecher</b>		M.D. <b>William A. Stecher</b>		PHYSICIAN'S NAME (Type) <b>WILLIAM A. STECHER</b>		RIVERDALE, MARYLAND		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Port Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F GASCH Sons</b>		ADDRESS <b>HYATTSVILLE Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>															



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14005

14012

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> c. LENGTH OF STAY IN TB <b>Jan-11/59</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PAINT BRANCH NURSING HOME</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b> d. STREET ADDRESS <b>2701 17th. street, N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>SAMUEL R. EDMONDS</b> 5 SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <b>12-18-1959</b> 8. DATE OF BIRTH <b>Oct. 21, 1880</b> 9. AGE (In years last birthday) <b>79 yrs</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CINDER BLOCK BUSINESS</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>WASHINGTON, D.C.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOHN ROBERT EDMONDS</b> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNIE BROWN</b> <b>16. SOCIAL SECURITY NO.</b> <b>579-03-3976</b> <b>17. INFORMANT</b> <b>HAZEL B. LA MAR</b> <b>3200 Cheverly Avenue, Cheverly, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease</b> <b>442.x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (d)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <i>John J. Maloney</i> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>		<b>CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b> <b>12-19-59</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>22b. DATE THEREOF</b> <b>12/21/1959</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>FORT LINCOLN CEMETERY</b> <b>22d. LOCATION (City, town, or county) (State)</b> <b>COLMAR MANOR, MARYLAND</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DEC 22 '59</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hanna</i>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Nalley's Funeral Home</i> <b>ADDRESS</b> <i>Mr. Reiner</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14017

CERTIFICATE OF DEATH

Reg. Dist. No. 14006

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PR. GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT RAINIER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT RAINIER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALBERT ERNEST EDWARDS</b>		4. DATE OF DEATH Month Day Year <b>DEC 8 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 22, 1881</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MILL</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ABRAHAM EDWARDS</b>		14. MOTHER'S MAIDEN NAME <b>POLLY MINTEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>271-03-7569</b>	
17. INFORMANT <b>CHANCEY EDWARDS</b>		Address <b>LAUREL, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF COLON</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>1 MONTH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOV 1, 1959</b> to <b>DEC 8, 1959</b> , that I last saw the deceased alive on <b>DEC 8, 1959</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel J. Sugar</b>		ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DRIVE</b> DATE SIGNED <b>Dec 8, 1959</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>		<b>MT RAINIER, Md.</b>	
22a. BURIAL, CREMATION, REINTERMENT		22b. DATE THEREOF <b>12-12-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grand-View</b>		22d. LOCATION (City, town, or county) (State) <b>Strasburg, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert X Amattiny</b>		ADDRESS <b>131-11 24th St Wash, D.C.</b>	
24a. REC'D BY REGISTRAR <b>DEC 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

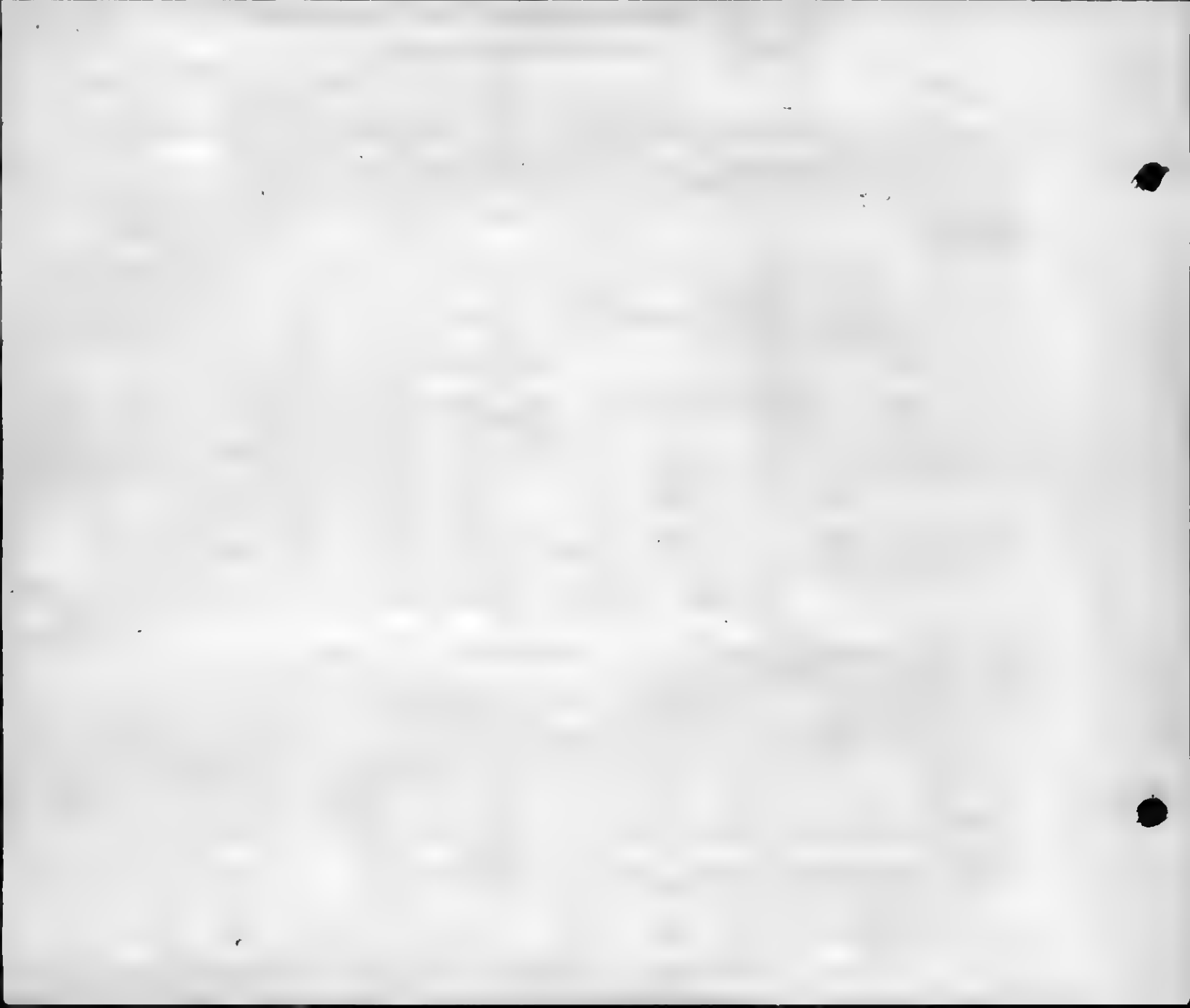
14102

## CERTIFICATE OF DEATH

14007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park, Suitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4615 Brookfield Dr.</u>				d. STREET ADDRESS <u>4615 Brookfield Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>R.</u> Last <u>EDWARDS</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1959</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>Caucas</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 14, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>							
13. FATHER'S NAME <u>William Bowman</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Gilbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Anna Tomlinson</u>		Address <u>4615 Brookfield Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular - renal disease</u> DUE TO <u>440 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>1 year</u> (c) <u>Hypertensive heart disease</u> DUE TO <u>15 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old left hemiplegia - 15 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>1 year</u> <u>15 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 2, 1956</u> , to <u>Dec - 26, 1959</u> that I last saw the deceased alive on <u>12-26-</u> 19 <u>59</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>David S. Gordon, M.D.</u>				<u>5731 23rd Parkway SE 1276 SE</u>			
PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON, M.D.</u>				<u>14007 211 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co Inc</u>				ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							





TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14005

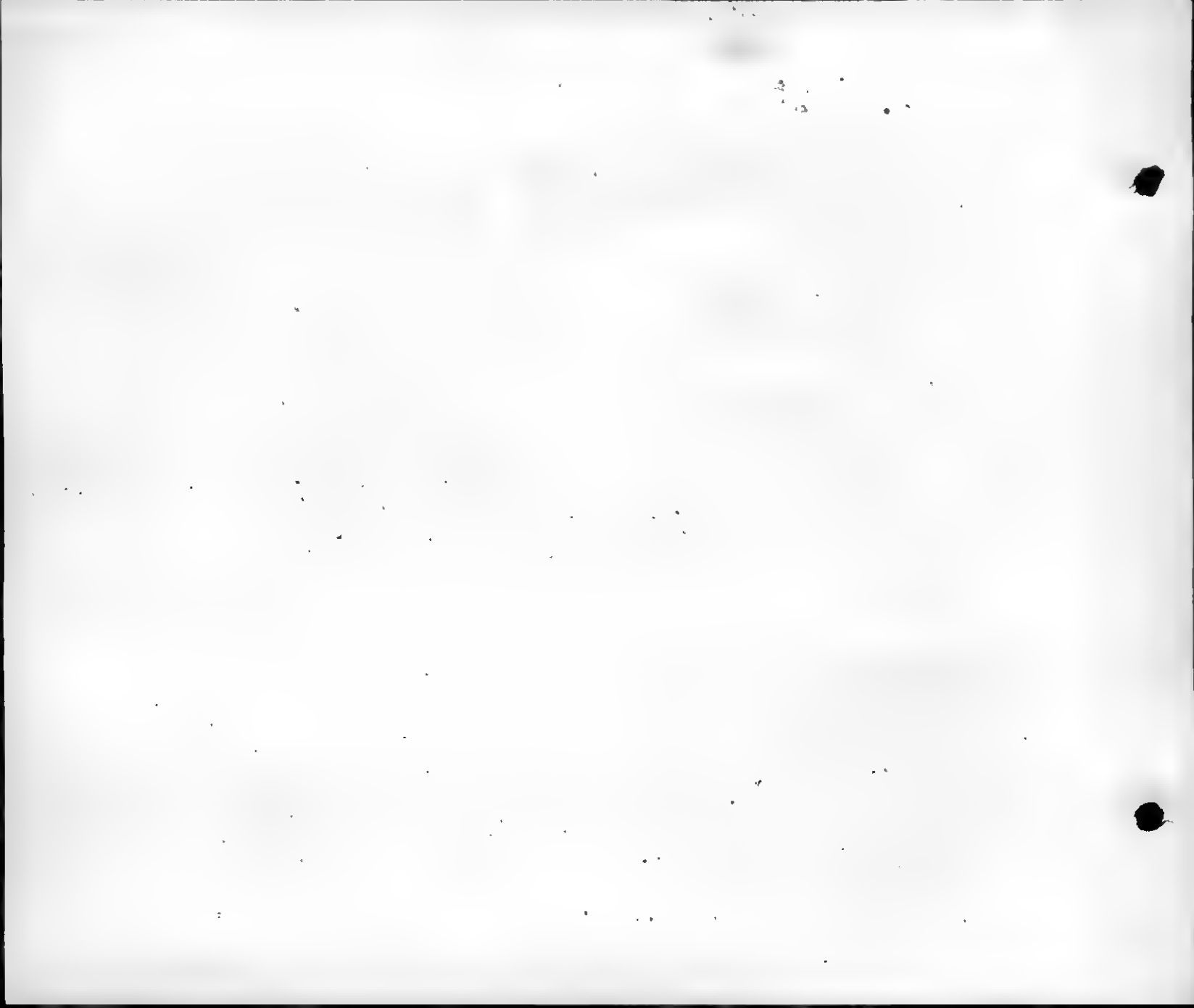
## CERTIFICATE OF DEATH

14008

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
c. LENGTH OF STAY IN 1b <u>10 yr.</u>		d. STREET ADDRESS <u>19001 48th Pl.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9001 - 48th Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>John Eshenour</u>		4. DATE OF DEATH Month Day Year <u>Dec 10 1959</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 10, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Eshenour</u>		14. MOTHER'S MAIDEN NAME <u>Annie Hacker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Lloyd Eshenour, College Park Md</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Cerebral atrophy &amp; degeneration</u> (b) DUE TO <u>permanent lrt hemiplegia</u> (c) DUE TO <u>from accident (1892)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs +</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Dragged by farm harrow</u>	
20c. TIME OF INJURY Month Day Year Hour a. m. <u>892</u> 19 <u>59</u> p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Farm</u>		20f (City or town) <u>Rutherford</u> (County) <u>Pa.</u> (State) <u>Pg.</u>	
21. I certify that I attended the deceased from <u>Aug 1949</u> to <u>DEC 59</u> , that I last saw the deceased alive on <u>DEC 10 1959</u> , and that death occurred at <u>535 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u>		DATE SIGNED <u>12/10/59</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		M.D. <u>4713 - Burgess Rd College Park, Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b DATE THEREOF <u>Dec 14, 1959</u>	22c NAME OF CEMETERY OR CREMATORY <u>Chambers - Hill</u>	22d LOCATION (City, town, or county) (State) <u>Harrisburg Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>4737 - Balt Ave.</u>		24a REC'D BY REGISTRAR <u>DEC 16 '59</u> 24b REGISTRAR'S SIGNATURE <u>C. Stuart S. Kraus</u>	

MEDICAL CERTIFICATION



## 14041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

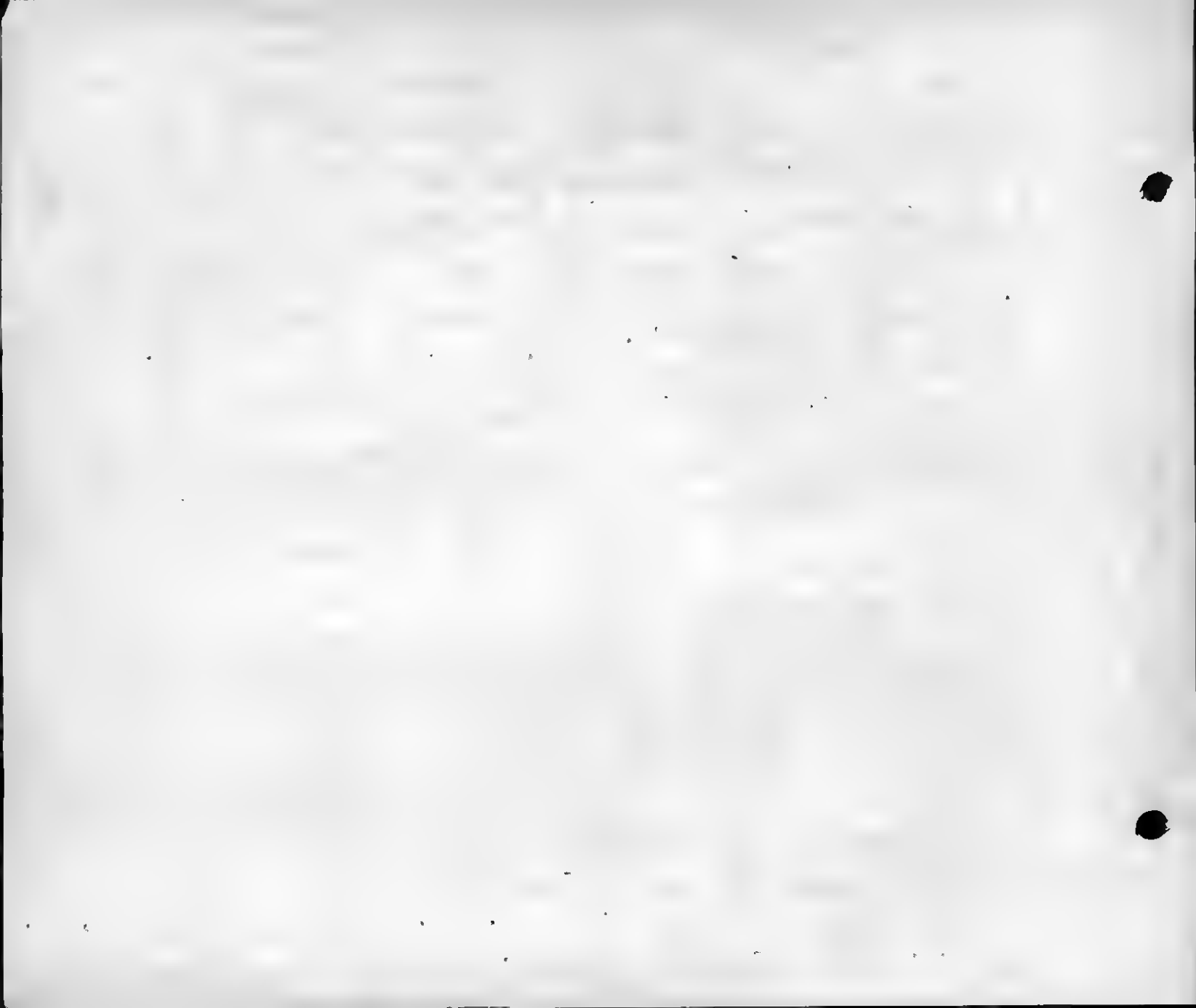
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Ge.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trinidad</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hosp.</u>				d. STREET ADDRESS <u>16416 - 46th Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Robert Ferguson</u>				4. DATE OF DEATH <u>Dec 17 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-81</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min. <u>17</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US Govt. Public Works</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Robert Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war & dates of service)				16. SOCIAL SECURITY NO. <u>Clinton Ferguson Same address</u>			
17. INFORMANT <u>Clinton Ferguson Same address</u>				Address <u>Clinton Ferguson Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic renal disease</u> (c) <u>renal disease</u> DUE TO <u>renal disease</u> cause lost. (c) <u>renal disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>renal disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John J. Malone</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John J. Malone M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-17-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Col-2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE DEC 21 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form EM-3. Page 1 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



14042

## CERTIFICATE OF DEATH

Reg. Dist. No.

14010

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>6107 59 Place</u>	
3. NAME OF DECEASED (Type or print) <u>IDA</u> First Middle Last		4. DATE OF DEATH <u>FERSTER</u> Month Day Year <u>Dec 2 - 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 26 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Gross</u>		14. MOTHER'S MAIDEN NAME <u>Rachel (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Necrosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-26</u> , 19 <u>58</u> , to <u>12-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-2</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hatfield Rd 122-1</u> DATE SIGNED <u>12-2-59</u>	
PHYSICIAN'S NAME (Type) <u>ARON DEITZ M.D.</u>		<u>4314 GALLATIN ST.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 4, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BROOKLYN N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. [Signature]</u> ADDRESS <u>Wash D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

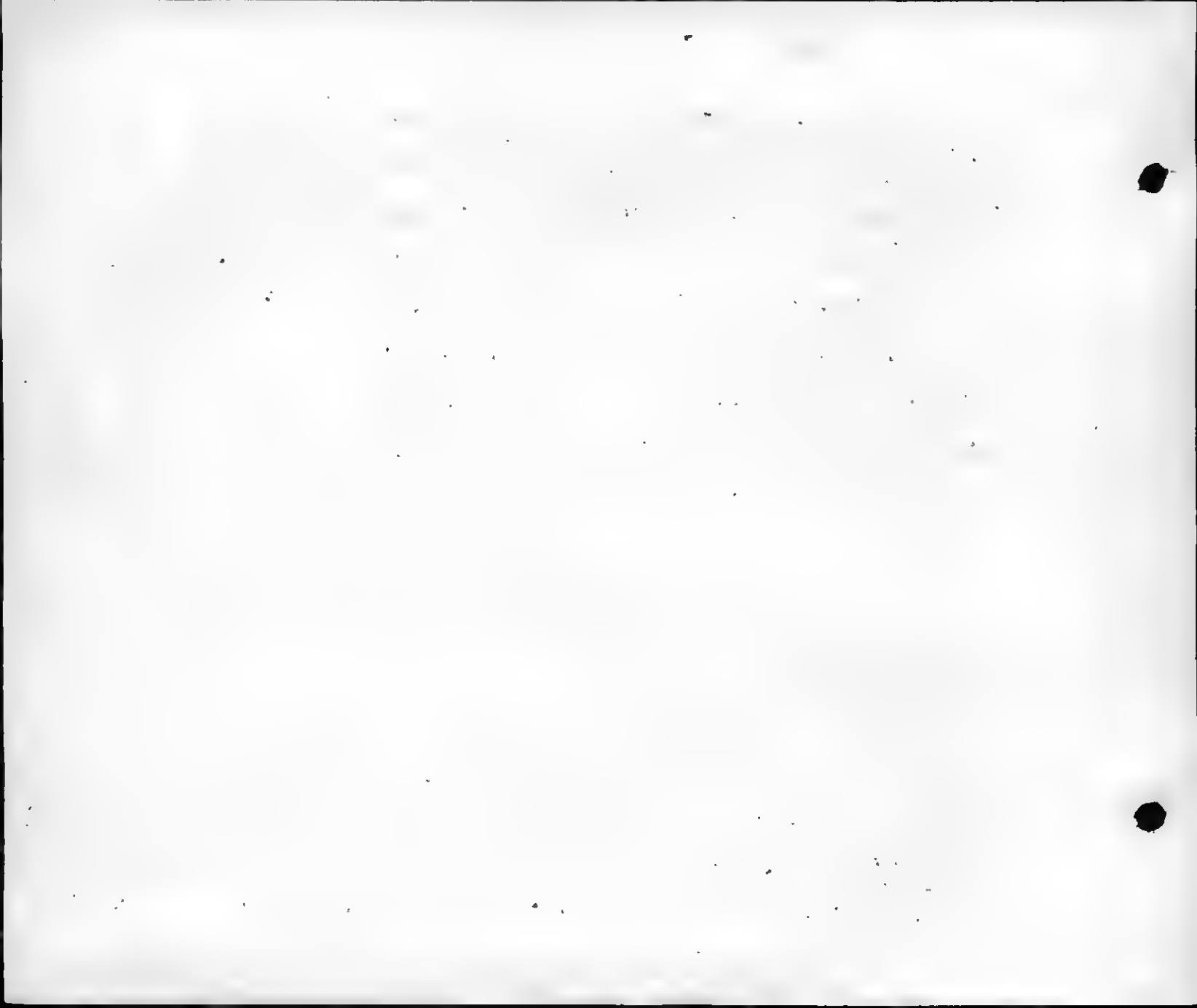
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then place in envelope carbon pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14018

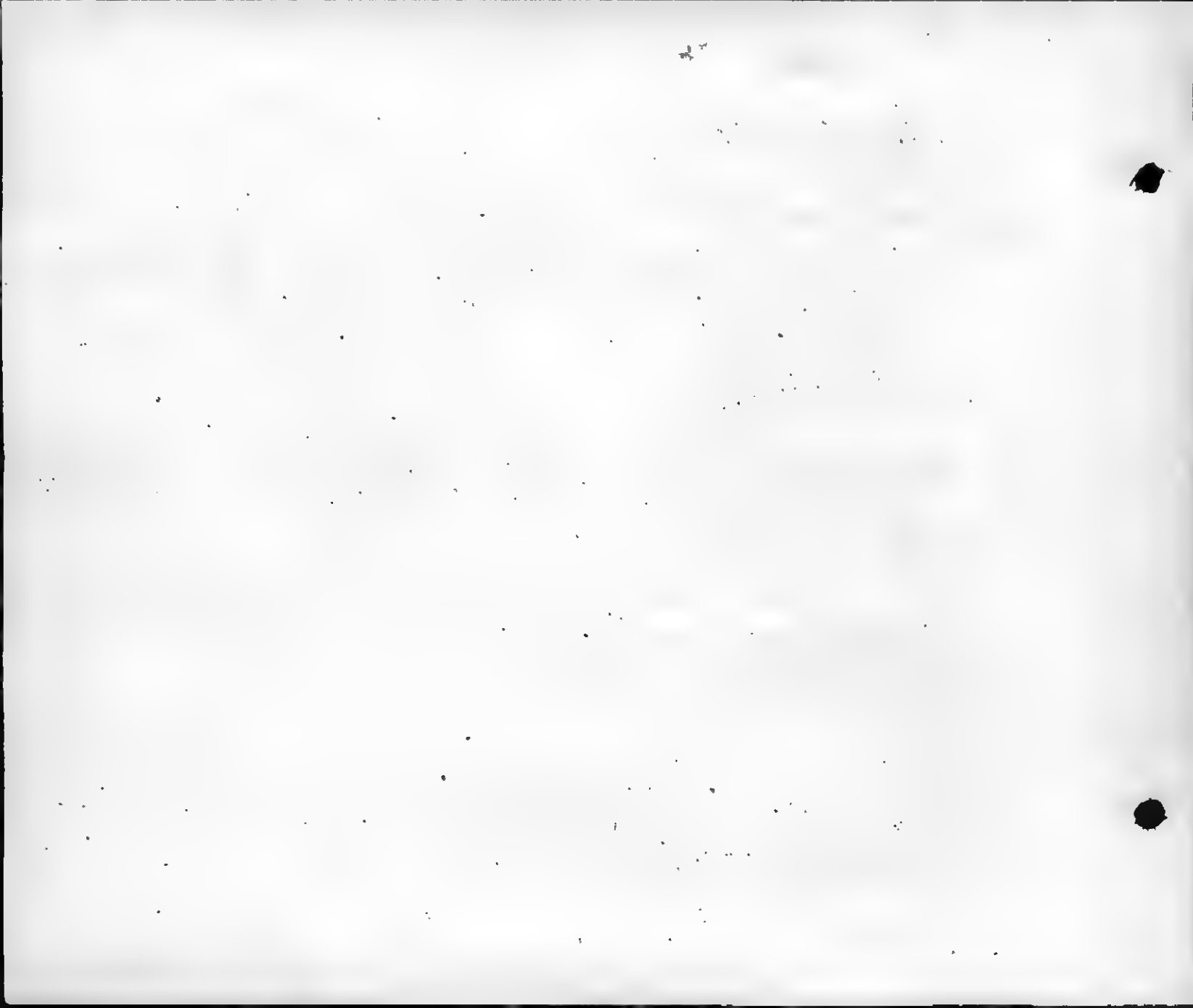
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4019-36 St.</i>		d. STREET ADDRESS <i>4019-36<sup>th</sup> street</i>	
3. NAME OF DECEASED (Type or print) <i>Eligabeth Alice Fleming</i>		4. DATE OF DEATH <i>Dec. 10, 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>21 Nov</i>
9. AGE (In years last birthday) <i>74</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife own home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>London England</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>	
13. FATHER'S NAME <i>David Hockney</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOC. SEC. NO. <i>Margaret C. Hazel</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>153.8 Cancer large intestine</i> DUE TO (b) <i>4 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive heart disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955 to 10 Dec</i> , 1959, that I last saw the deceased alive on <i>9 Dec</i> , 1959, and that death occurred at <i>8 a. m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas E. Mattingly M.D.</i>		ADDRESS (Street, city or town, state) <i>2200 R. I. Ave N.E. 18, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Thomas E. Mattingly, M.D.</i>		DATE SIGNED <i>10 Dec 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/12/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Halley's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier Md.</i>	
24a. RECEIVED BY REGISTRAR <i>DEC 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hanna</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





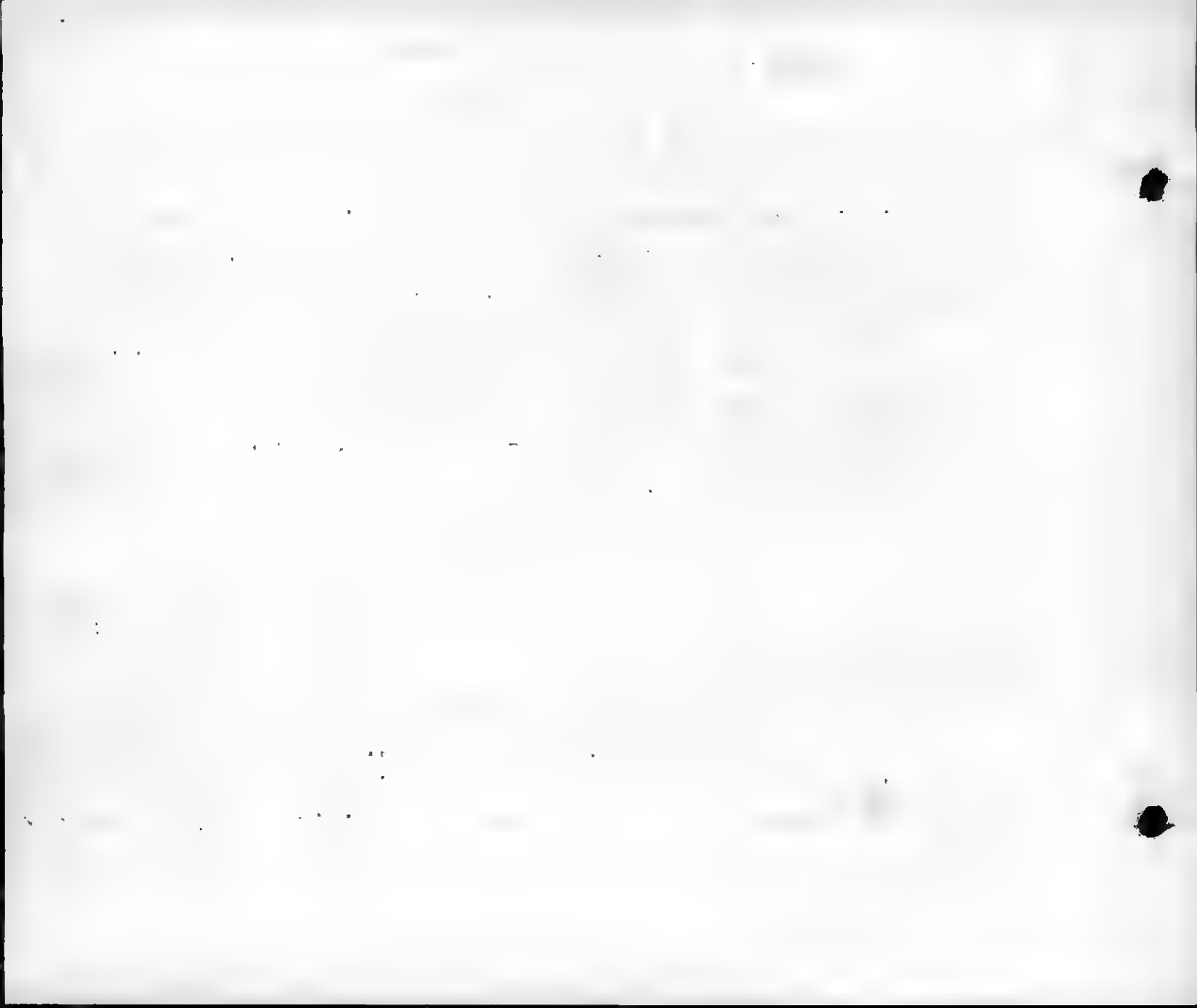
## CERTIFICATE OF DEATH

Reg. Dist. No.

14012

14043

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Radiant Valley</b> d. STREET ADDRESS <b>6838 Barton Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Sophia</b> Middle <b>Brantz</b> Last <b>Fletcher</b> 4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>1959</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Nov. 16, 1959</b> 9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b> 11. BIRTHPLACE (State or foreign country) <b>Illinois</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ernest Brantz</b> 14. MOTHER'S MAIDEN NAME <b>Elizabeth Reit</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>357-22-5724</b> INFORMANT <b>Sam-Richard D. Fletcher Jr.</b> Address		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalomalacia</b> <b>302x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ischemic infarction</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multifocal gastric ulcers.</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>Nov. 24</b> , 1959, to <b>Dec. 3</b> , 1959, that I last saw the deceased alive on <b>Dec. 3</b> , 1959, and that death occurred at <b>2:35 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>4410 74th Ave., Hyattsville, Md.</b> PHYSICIAN'S NAME (Type) <b>Colmor Manor, Md.</b>			
22a. BURIAL, CREMATION, REINTERMENT <b>Colmor Manor, Md.</b> 22b. DATE THEREOF <b>12-5-1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b> 22d. LOCATION (City, town, or county) (State) <b>Colmor Manor, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wm. Lee's Sons Co.</b> ADDRESS <b>Wash. 2 D.C.</b> 24a. REC'D BY REGISTRAR <b>DEC 7 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



14044

## CERTIFICATE OF DEATH

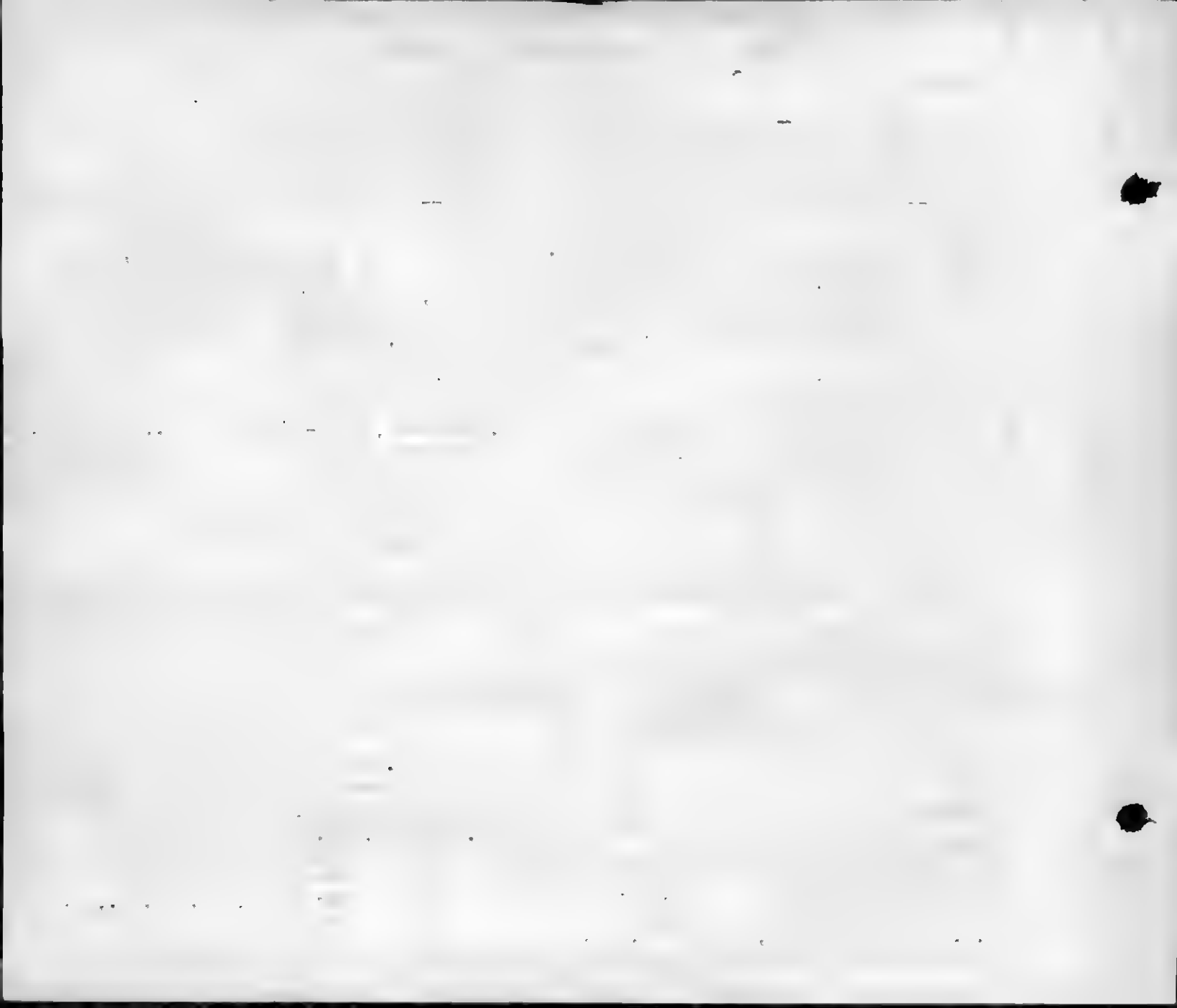
14013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>				c. LENGTH OF STAY IN 1b <b>8 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>38 F--Crescent Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>FANNIE H.</b> Last <b>FLORENCE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>29th</b> , Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5th, 1886</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Taneytown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Tobias Martin</b>				14. MOTHER'S MAIDEN NAME <b>Ida (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Paul R. Florence, 38 F--Crescent Rd., Greenbelt, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>12/2</b> , 19 <b>58</b> , to <b>12/29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/14</b> , 19 <b>59</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3503 Perry Street, Mt. Rainier, Md.</b> DATE SIGNED <b>12/30/1959</b>							
ACTUAL SIGNATURE <b>Norman D. Comeau</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Norman D. Comeau</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/2/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G-54 1-4-60 et

14006

## CERTIFICATE OF DEATH

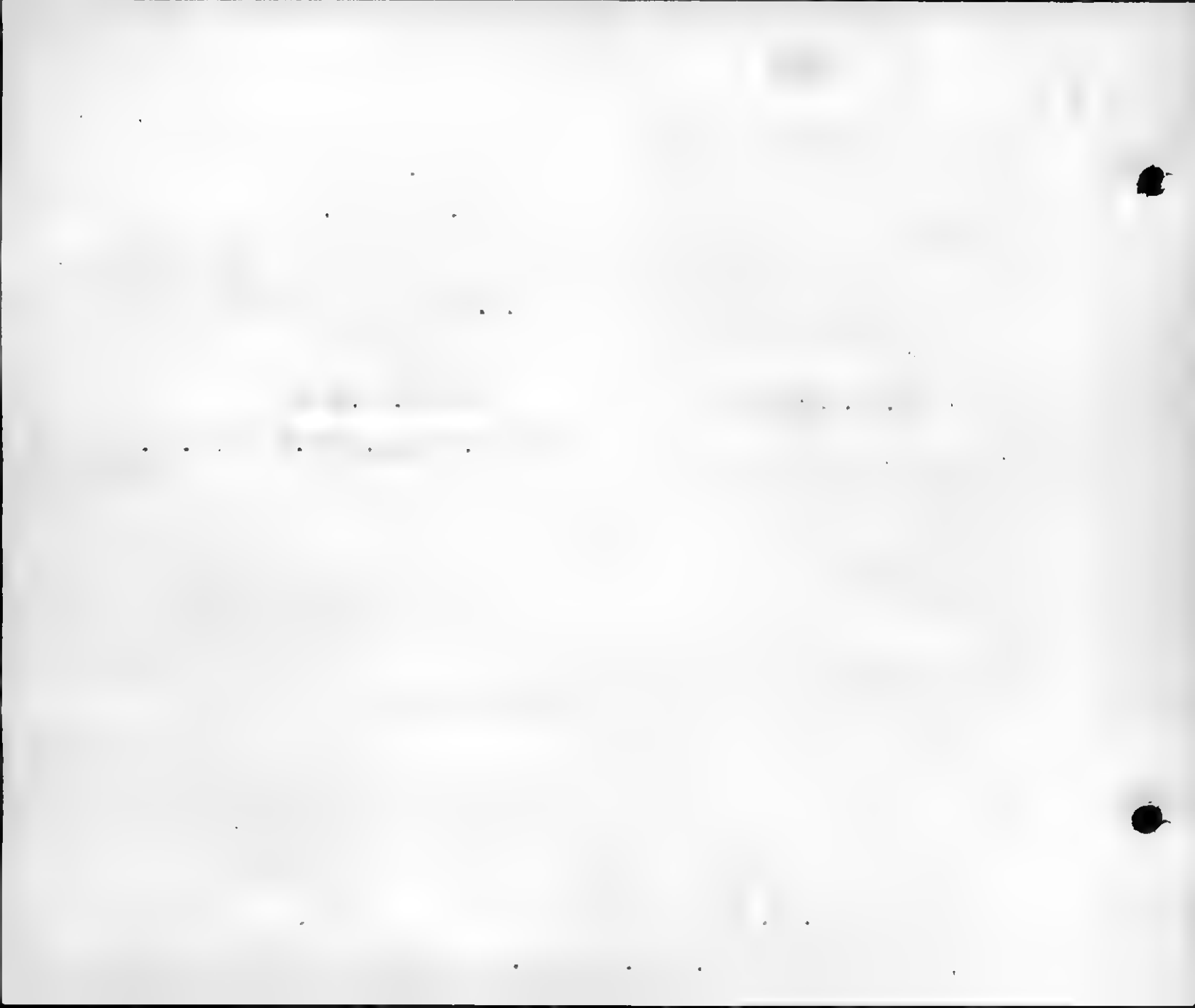
Reg. Dist. No.

14014

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLD</u> b. COUNTY <u>PR. GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>French</u> Last <u>French</u>				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4.1.1902</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. T.</u>			
13. FATHER'S NAME <u>John. C. French</u>				14. MOTHER'S MAIDEN NAME <u>Jennie. E. Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mildred. Wagner. 4618. Harvard. Rd. College</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>left breast.</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>MAY</u> 19 <u>59</u> , to <u>Dec. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 25</u> , 19 <u>59</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Leonard Gold</u> M.D.				ADDRESS (Street, city or town, state) <u>8641 Colesville Road Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>				DATE SIGNED <u>DEC 29 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12.28.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>300. 4th. st N E.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. &amp; F. Hall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

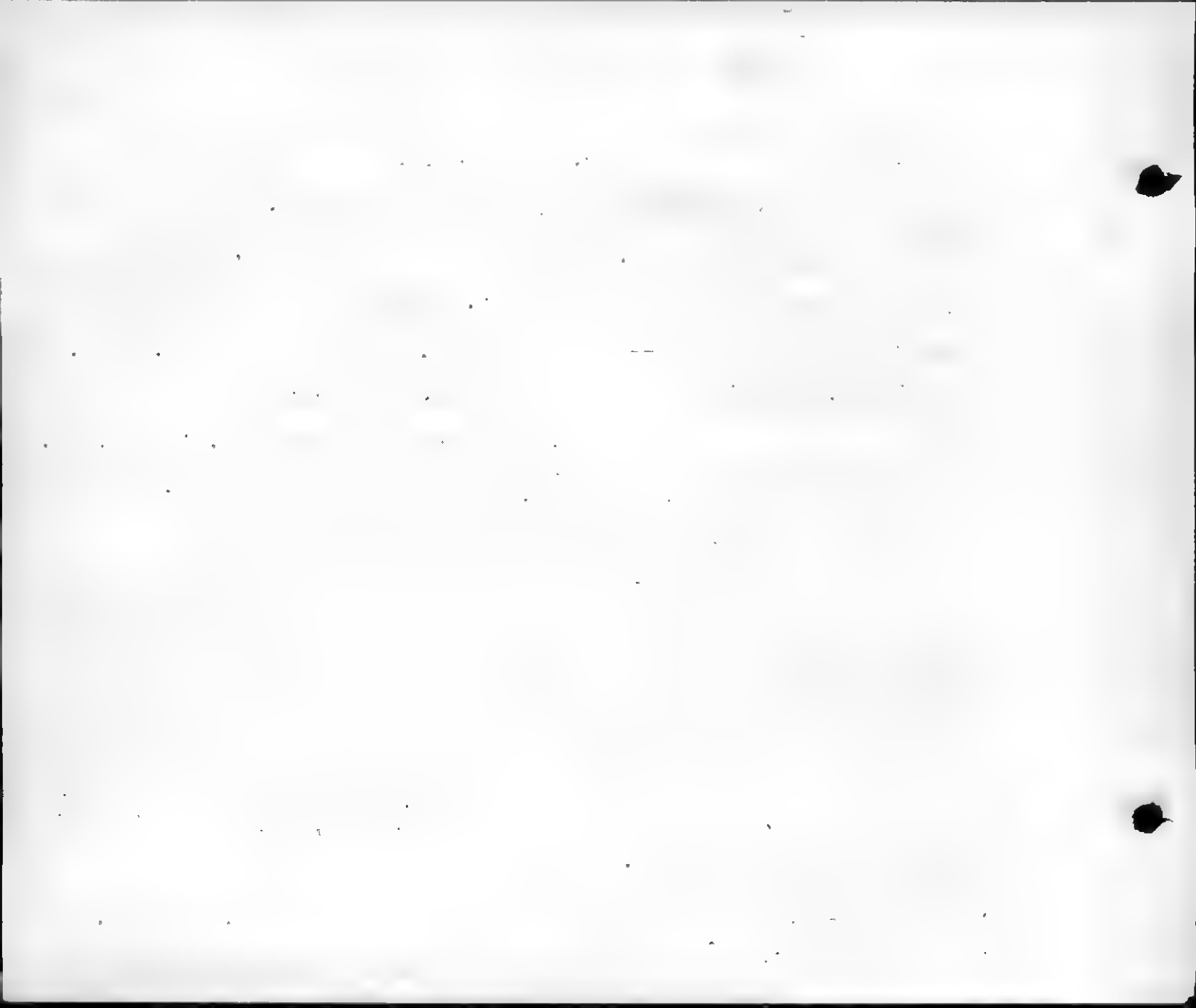
Reg. Dist. No.

14015

14045

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Johanna</b> Middle <b>L.</b> Last <b>Funk</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>31</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 31, 1892</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William E. Emmerich</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Demmo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>	
17. ADDRESS <b>Carl V. Funk 7802 Cross St. Lanham, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, massive, acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Coronary Artery Disease +</b> (c) <b>Coronary Occlusion</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/17</b> , 19 <b>59</b> , to <b>12/31</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/31/59</b> , 19 <b>59</b> , and that death occurred at <b>5:40 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Barry Rosenberg</b>		ADDRESS (Street, city or town, state) <b>5102 Annapolis Road Bladensburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Barry Rosenberg.</b>		DATE SIGNED <b>12/31/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-5-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		24a. REC'D BY REGISTRAR <b>3704 North Ave</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>		DATE <b>JAN 4 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





14046

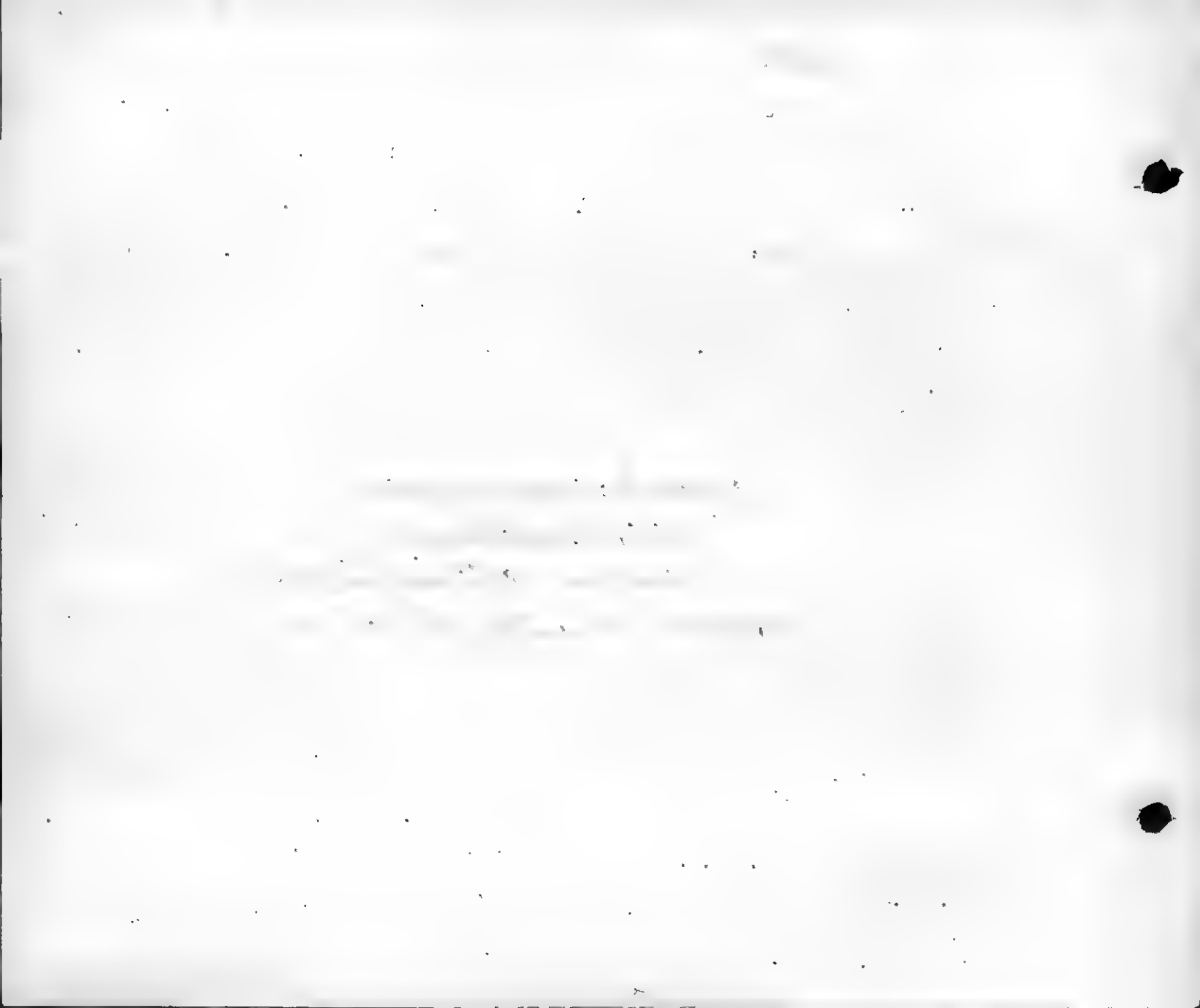
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>137 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>817 58 th Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>B</b> Last <b>Garrett</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 April 1901</b>	9. AGE (In years last birthday) yrs. <b>58</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	IF UNDER 24 HRS Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Emmett Garrett</b>				14. MOTHER'S MAIDEN NAME <b>Emma Bruce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>WW 2</b>		INFORMANT <b>Robina S. Garrett</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Encephalomalacia</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Sept</b> 1957, to <b>Dec 28th</b> 1959, that I last saw the deceased alive on <b>28 Dec.</b> 1959, and that death occurred at <b>3:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Peter Duus</b>				ADDRESS (Street, city or town, state) <b>6117 Clearfield Drive Seat Pleasant, Md</b>		DATE SIGNED <b>28 Dec. 59</b>	
PHYSICIAN'S NAME (Type) <b>Peter Duus., M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl</b>		22d. LOCATION (City, town, or county) (State) <b>28 Myer, Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. G. Matteringly</b>				ADDRESS <b>131-114 St. E.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14047 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 11 Filed 53 12-29-59 et  
CERTIFICATE OF DEATH

14017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>5507 Sheriff Road</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Gordon</b>				4. DATE OF DEATH Month Day Year <b>Dec. 14 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 Nov 1881</b>	
9. AGE (In years lost birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Samuel</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Shorter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Informant</b>		Address <b>5507 Sheriff Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolism with lung carcinoma at base</b> 153.3 DUE TO (b) <b>Cardiac arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) <b>Extensive carcinoma of the sigmoid colon</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 14</b> , 19 <b>59</b> , to <b>Dec 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 14</b> , 19 <b>59</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. Louis Mendel</b>				ADDRESS (Street, city or town, state) <b>4506 COLLEGE AVE</b> DATE SIGNED <b>12/15/59</b>			
PHYSICIAN'S NAME (Type) <b>C. LOUIS MENDEL</b>				COLLEGE PARK MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>12-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		22d. LOCATION (City, town, or county) (State) <b>SHERRIFF RD EX. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.S. Washington</b> ADDRESS <b>4925 Dean Ave NE</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



14048  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pr George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 325 Main Street		1d STREET ADDRESS 325 Main St	
3. NAME OF DECEASED (Type or print) Vincent First Middle Last Greco (GRECO)		4. DATE OF DEATH Dec 12 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Own bakery shop	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nancy Greco		14. MOTHER'S MAIDEN NAME Rose Fava	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Theresa Greco Laurel Md		Address 325 Main St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis DUE TO (c) coronary thrombosis.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 12-11, 1959, and that death occurred at _____ M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ydolo PIERANDREI M.D.			
PHYSICIAN'S NAME (Type) IDOLO PIERANDREI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral in Baltimore Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) Mr. Will Handman, Laurel Md		24a. REC'D BY REGISTRAR DATE DEC 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

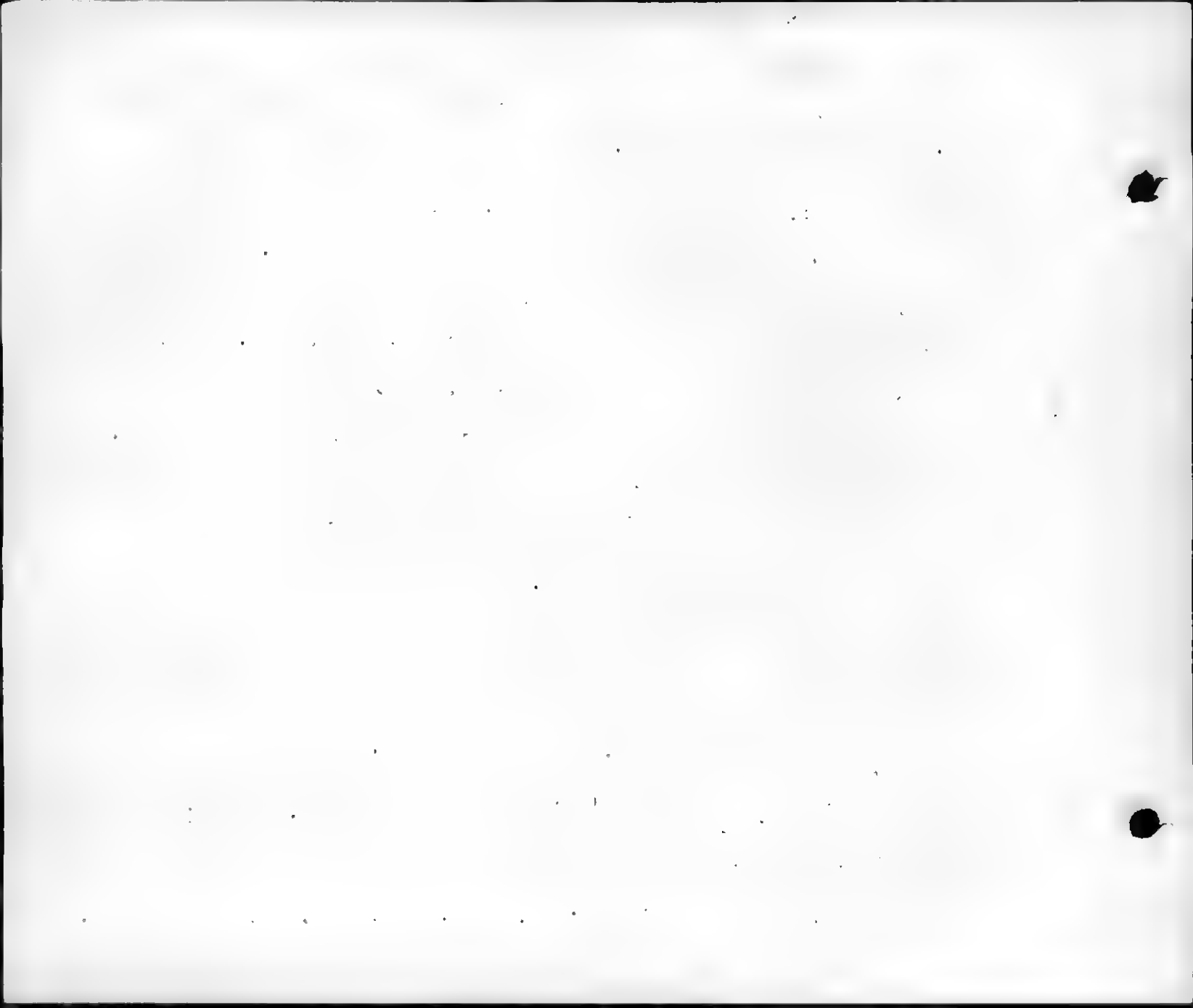
14019

14049

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b> c. LENGTH OF STAY IN lb <b>6 da.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2 USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Clinton</b> d. STREET ADDRESS <b>Rt.2 Box 284</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Green</b>		4. DATE OF DEATH Month Day Year <b>Dec. 23 19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6-6-56</b>
9. AGE (In years last birthday) yrs <b>3</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None- child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Prince Geo.Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Alvin Green</b>		14. MOTHER'S MAIDEN NAME <b>Elsa M. Savoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>James Alvin Green</b> Address <b>Clinton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>432x</b> DUE TO <b>Pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac decompensation</b> DUE TO <b>Cardiac decompensation</b> (c) <b>Arrhythmia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 17, 19 59</b> to <b>Dec. 23, 19 59</b> , that I last saw the deceased alive on <b>Dec. 23, 19 59</b> , and that death occurred at <b>10:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bertha Van Gelderen</b>		ADDRESS (Street, city or town, state) <b>3001 Choverly Ave, Choverly, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Bertha Van Gelderen</b>		DATE SIGNED <b>DEC 28 '59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary St. John</b>	22d. LOCATION (City, town, or county) (State) <b>Clinton Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Myrtle Williams</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
ADDRESS <b>4339 Lindberg</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1-10-60

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Goodwood Farm			d. STREET ADDRESS Rt. 1 Box 63		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Carter, Frances Hall			4. DATE OF DEATH Dec 15 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1890		9. AGE (in years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KNOWN SIBLING (Incest) None		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Nicholas Ansdon Hall			14. MOTHER'S MAIDEN NAME Estelle Gilpin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 577-22-9834		
17. INFORMANT Mr. Catherine E. Hall, Armacos #2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure 44 x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James T. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) JAMES T. BOYD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Dec 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	
				22d. LOCATION (City, town, or county) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

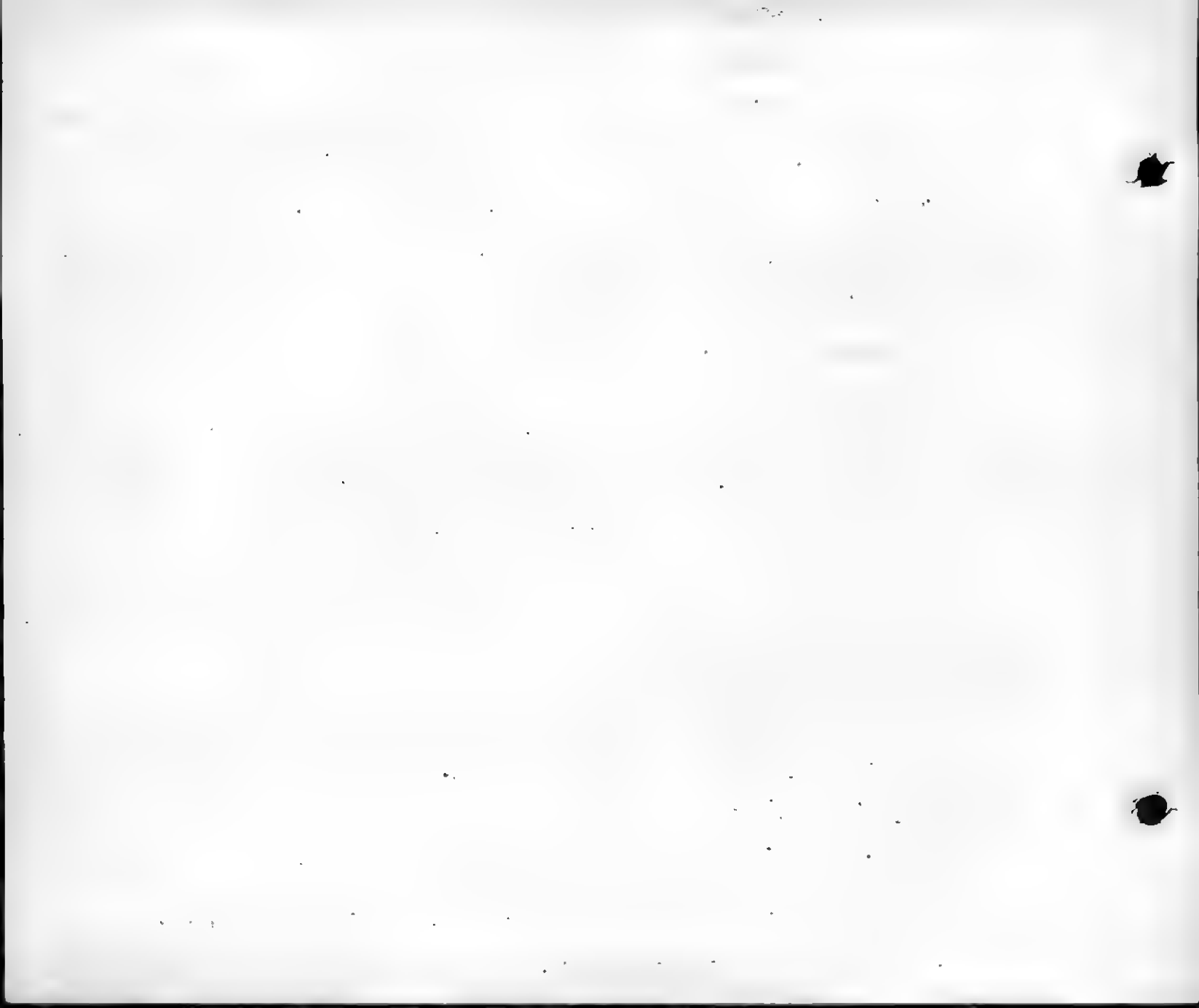
14021

14050

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 3, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	11. IF UNDER 24 HRS Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Hall</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>Mildred H Campbell</b>		Address <b>Los Angeles California.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>450.1</b> DUE TO <b>Coronary Thrombosis with myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>NOV 29</b> , 19 <b>59</b> , to <b>DEC 1</b> , 19 <b>59</b> , that I lost saw the deceased alive on <b>Nov 30</b> , 19 <b>59</b> , and that death occurred on <b>23</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. L. ETIENNE</b>		ADDRESS (Street, city or town, state) <b>4713 - BERWYN Rd College PK, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>		DATE SIGNED <b>12-1-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/3/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. France</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14023

{State}

24b. REGISTRAR'S SIGNATURE

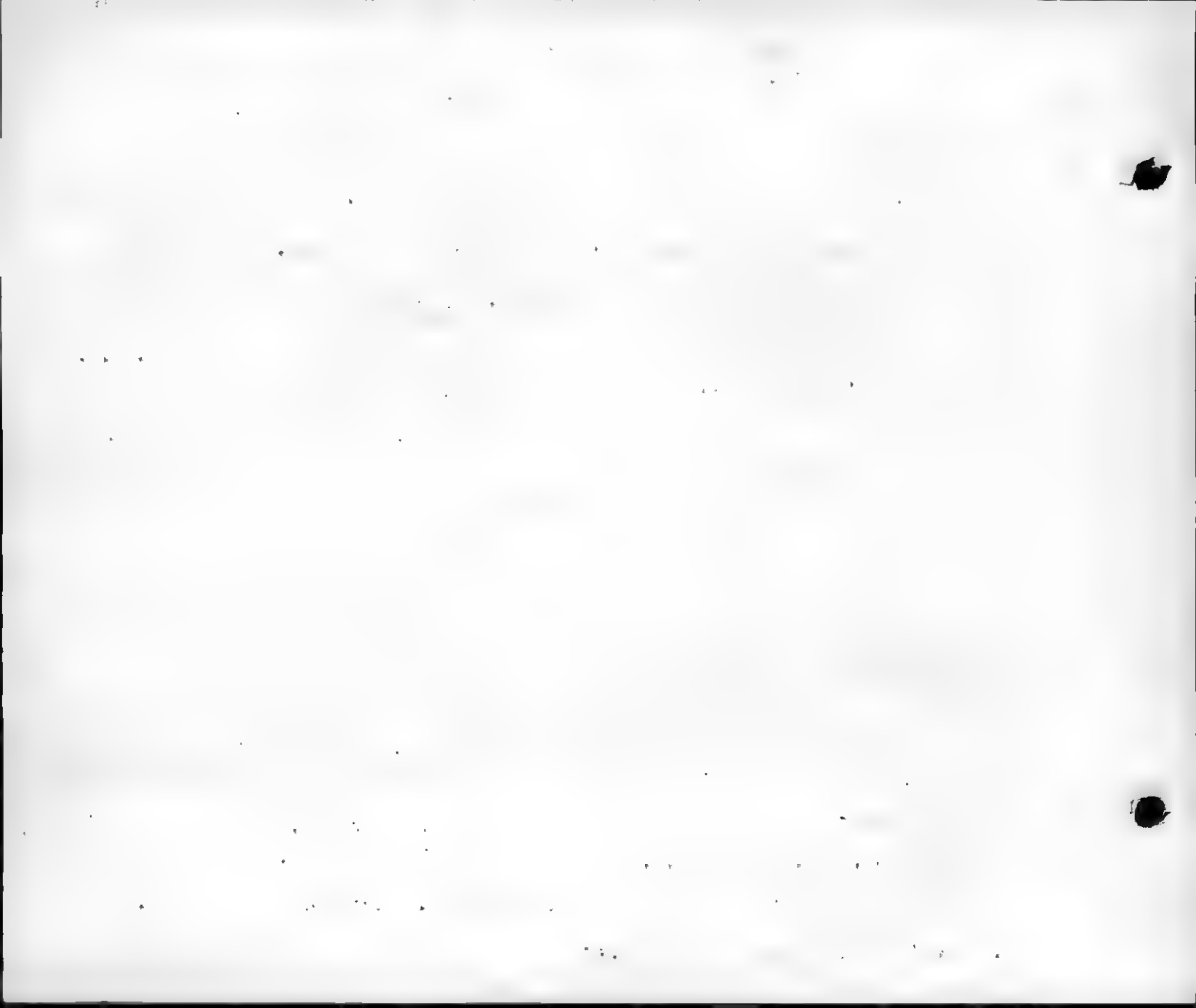
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DATE DEC 23 '59

Cullen &amp; Kraus

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2016



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14104

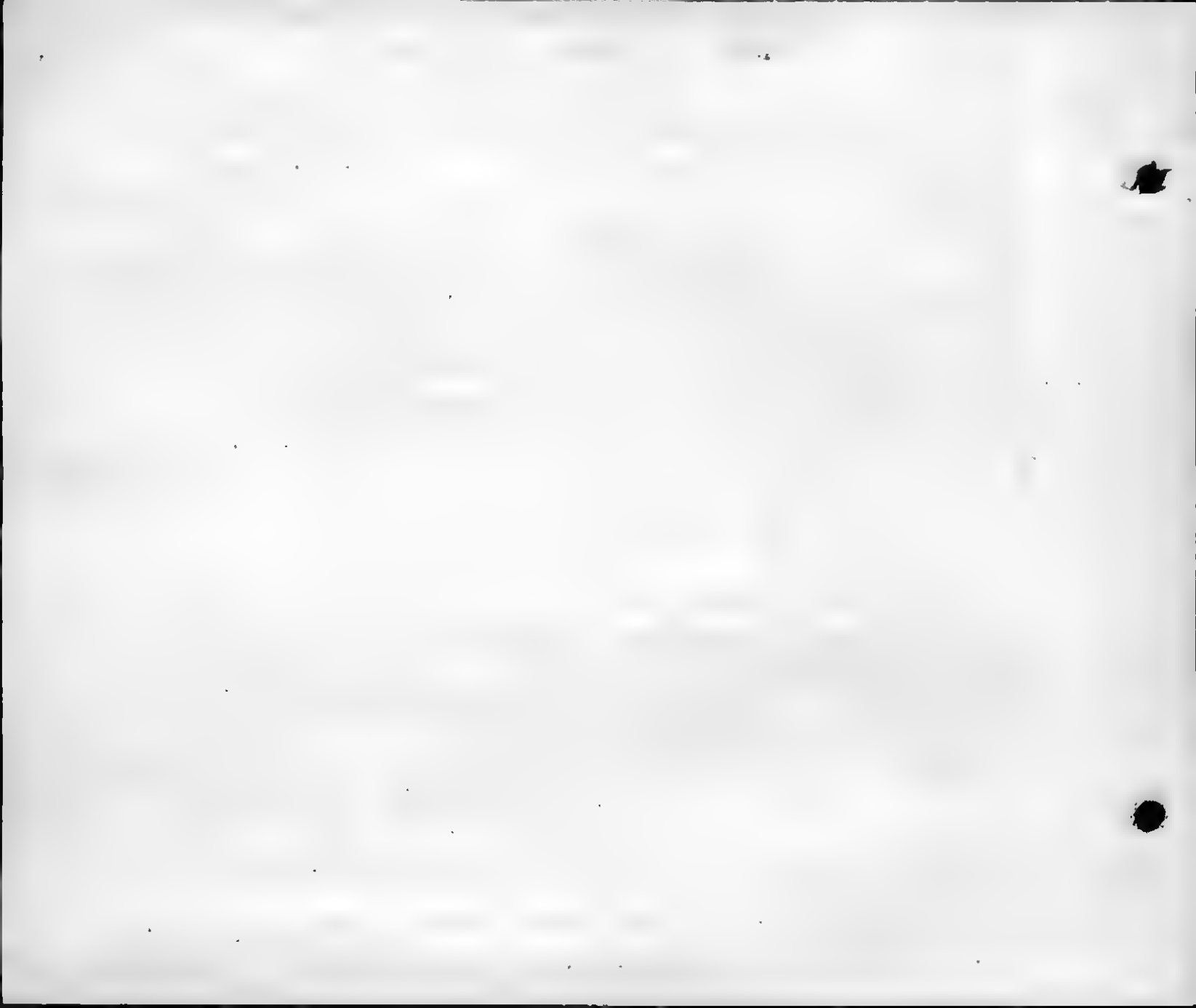
## CERTIFICATE OF DEATH

Reg. Dist. No.

141024

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie Md</b>		c. LENGTH OF STAY IN 1b <b>21 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1518 Chesnut avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Agusta</b> First <b>Elizabeth</b> Middle <b>Harding</b> Last		4. DATE OF DEATH Month <b>Dec</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Treasurer Dept</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Reum</b>		14. MOTHER'S MAIDEN NAME <b>Annie Lyon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Richard Reum</b>		Address <b>Bowie, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis with Invasive Metastasis to right lung</b> DUE TO (b) <b>Carcinoma of Scalp</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>2 year</b> <b>18 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/12</b> to <b>12/13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/12</b> , 19 <b>59</b> , and that death occurred at <b>10:55</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. James Kurtz</b> M.D.		DATE SIGNED <b>12/13/59</b>	
PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>		ADDRESS (Street, city or town, state) <b>R F D Bowie, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 16, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





14105

Item 2. See: Birth Cert. et

CERTIFICATE OF DEATH

14025

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>NONE</b> Anne Arundel b. COUNTY <b>NONE</b> Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>				c. LENGTH OF STAY IN 1b <b>25 HRS 24 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Beach</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>Albany &amp; Alabama Avenues</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NEWBORN</b> Middle <b>HAYMAN</b> Last				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 DECEMBER 1959</b>	
9. AGE (In years lost birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>ROBERT L HAYMAN</b>				14. MOTHER'S MAIDEN NAME <b>HELEN J YORKLAND</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Distress of Newborn</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Premature birth</b>						INTERVAL BETWEEN ONSET AND DEATH <b>22 hrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>28 Dec</b> , 19 <b>59</b> , to <b>29 Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>0410 29 Dec</b> , 19 <b>59</b> , and that death occurred at <b>0410 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>John A Moore</b> M.D. <b>USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25 DC</b> PHYSICIAN'S NAME (Type) <b>JOHN A MOORE, CAPT, USAF, MC</b> <b>USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25 DC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>12-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>--</b>		22d. LOCATION (City, town, or county) (State) <b>--</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hospital</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Home</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

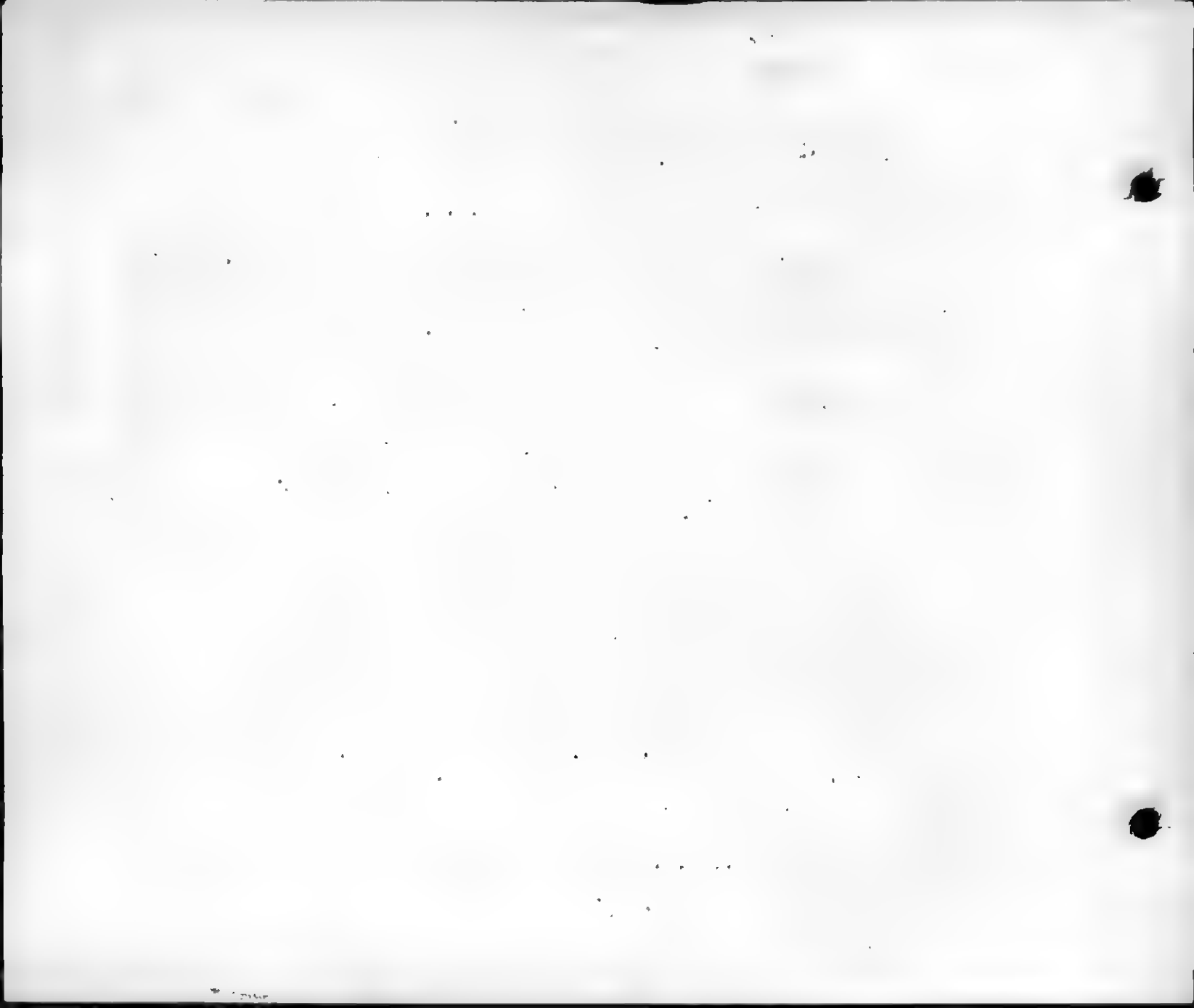
Reg. Dist. No.

14052

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henson</b> Middle <b>Henry</b> Last <b>Henry</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>27</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Henry</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Elizabeth Henry</b>		Address <b>Wife</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>491X</b> <b>491X</b> DUE TO <b>Cholera with virus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>from stool.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic nephrosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 Dec. 1959</b> , 19____, to <b>27 Dec.</b> , 19____, that I last saw the deceased alive on <b>27 Dec. 1959</b> , 19____, and that death occurred at <b>6:50 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Till Bergmann</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Till Bergmann, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-31-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Family Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodmare Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Washington</b>		24a. REC'D BY REGISTRAR <b>JAN 4 60</b>	
ADDRESS <b>4925 Dean Ave NE</b>		24b. REGISTRAR'S SIGNATURE <b>Christ S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

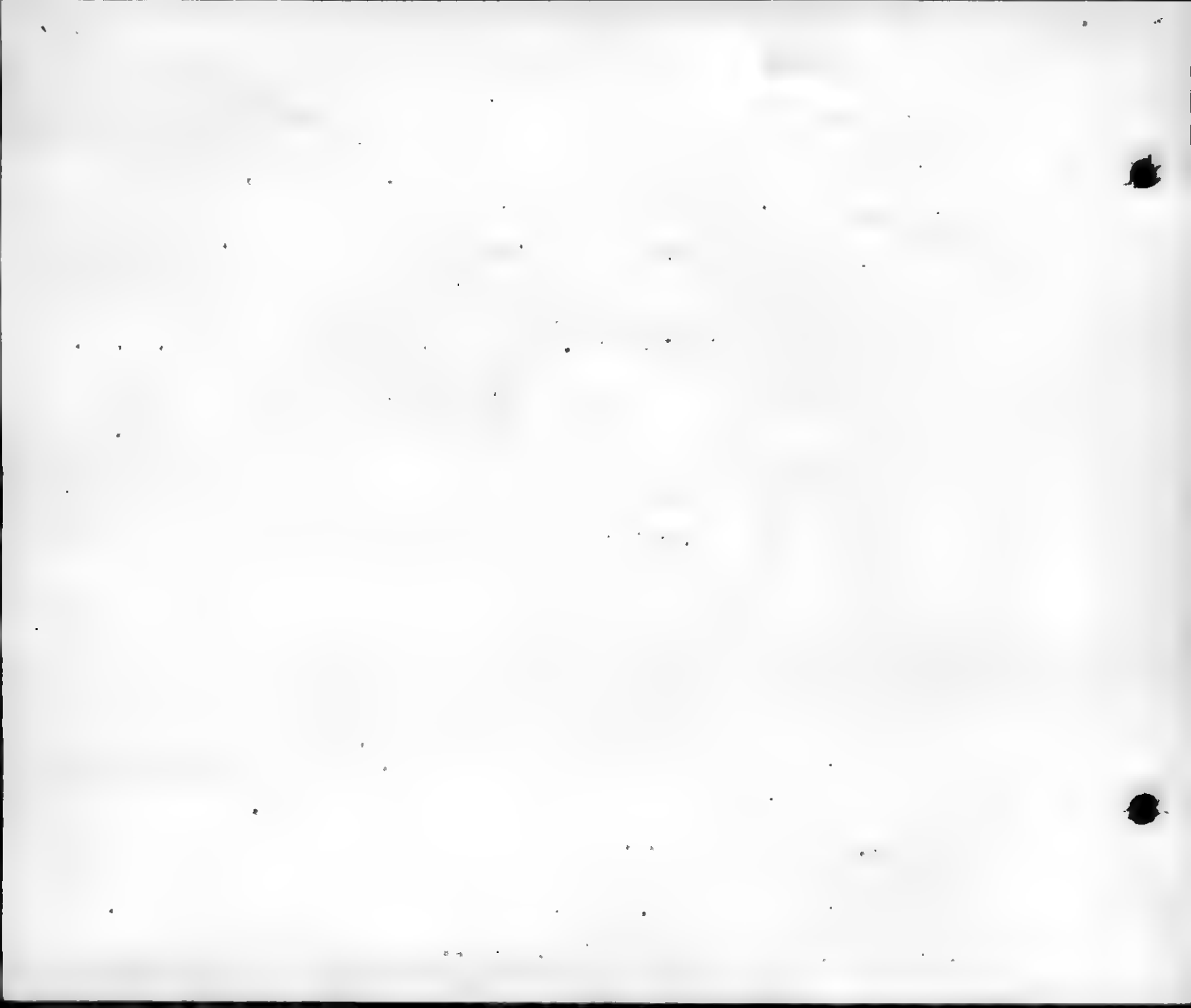
## CERTIFICATE OF DEATH

Reg. Dist. No. 14027

14053

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>15 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Star Route, BOX 20</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willard</b> Middle <b>Dewey</b> Last <b>Hook</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1898</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>19</b>	11. IF UNDER 24 HRS Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>XXXXXX Pub. Works</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Pinkney Hook</b>		14. MOTHER'S MAIDEN NAME <b>Annie Eliza Duley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>XX Unknown</b>		16. SOCIAL SECURITY NO. <b>XXXXXX</b>	
17. INFORMANT Address <b>Emily Viola Hook -Same As Above.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Bilateral Pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 Days</b> <b>3 Mos</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 hr</b> 1957 to <b>Dec. 25</b> 1959, that I last saw the deceased alive on <b>24 Dec</b> 1959, and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro, Md.</b> DATE SIGNED <b>12/25/59</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Robert Sasscer, M.D.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Croom Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Itchie Bros. Funeral Home -</b>		24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>	
ADDRESS <b>Upper Marlboro, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14105

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11028

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 381</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
		f. STREET ADDRESS <u>Route 381</u>	
3. NAME OF DECEASED (Type or print) <u>Victor Arthur Horton</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur A. Horton</u>		14. MOTHER'S MAIDEN NAME <u>Eva Crouch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1923-1925</u>		16. SOCIAL SECURITY NO. <u>221-36-6471</u>	
17. INFORMANT <u>Martha Virginia Horton, same as *</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>Dec 16, 1959</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lynchburg, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>DEC 21 '59</u>	
ADDRESS <u>Codre, Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





14054

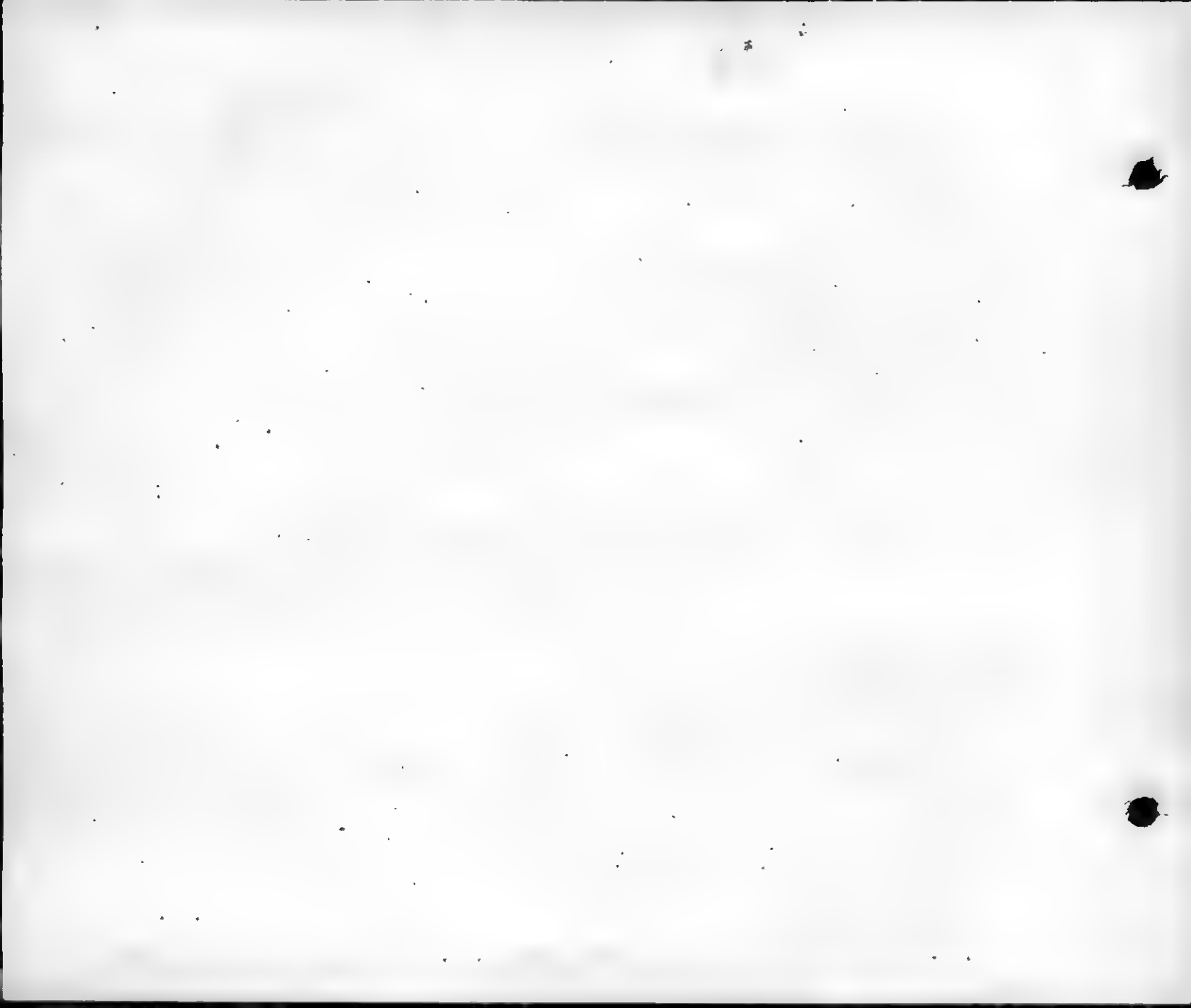
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel (West)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		e. STREET ADDRESS <u>Maple Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>M.</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Anne Cochran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs C. Ostmann - Maple Ave. - West Laurel - Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 322x DUE TO (b) <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Many years</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 28, 1959</u> to <u>Dec. 20, 1959</u> that I last saw the deceased alive on <u>Dec 19, 1959</u> and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Higgins</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u> DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Higgins M.D.</u>		<u>Laurel Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/50</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Hurtemann &amp; Son</u>		ADDRESS <u>5732 Georgia Ave N. W.</u>	
24a. REC'D BY REGISTRAR <u>DATE DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14055

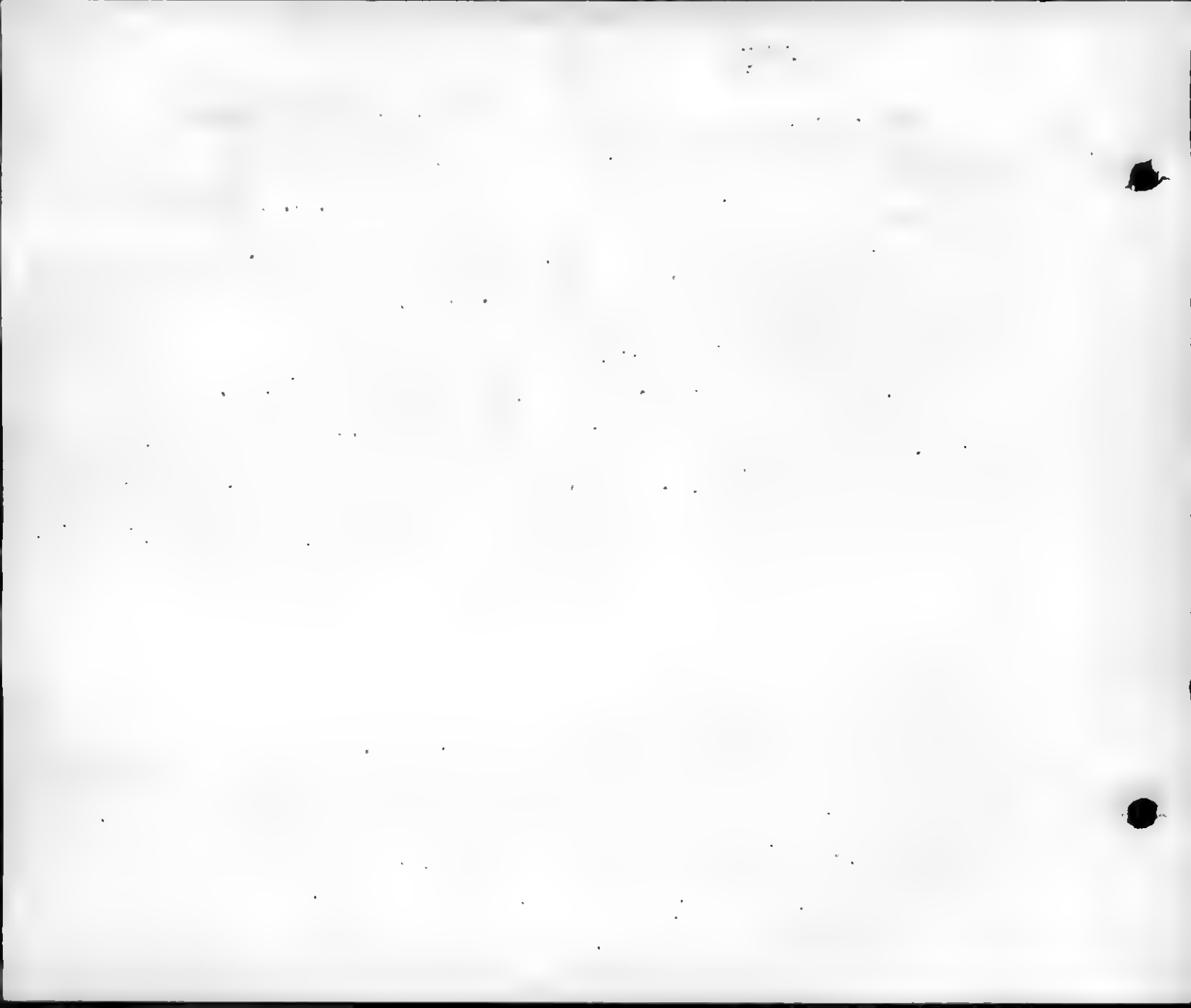
## CERTIFICATE OF DEATH

14050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>G</b> Last <b>Jackman</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1873</b>
9. AGE (In years less than day) yrs. <b>86</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS Months <b>3</b> Days <b>1</b> Hours <b>1</b> Min.
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua Jackman</b>		14. MOTHER'S MAIDEN NAME <b>Aurelia Hunt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>577-09-5763A</b>	
17. INFORMANT <b>Mrs. Sarah E. Jackman</b>		Address <b>5802 Central Ave. Wash. D.C. S.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.1</b> DUE TO <b>Heart valve &amp; in intentional homicide</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the colon (transverse) approx 1 yr.</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1</b> , 19 <b>58</b> to <b>Dec. 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 7</b> , 19 <b>59</b> , and that death occurred at <b>6:55 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Brainin</b> M.D.		ADDRESS (Street, city or town, state) <b>6124 Central Ave</b>	
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		DATE SIGNED <b>12/7/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers &amp; Co Inc</b>		ADDRESS <b>Washington D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 10 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14056

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bheverly</b> c. LENGTH OF STAY IN lb <b>7 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>5107 Edgewood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Baby <b>Boy</b> ) <b>John Carroll Jackson</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1959</b>
9. AGE (In years last birthday) — yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>18</b> Hours <b>20</b> Min.	11. IF UNDER 24 HRS Hours <b>20</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None--Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Eugene Jackson</b>	
14. MOTHER'S MAIDEN NAME <b>Barbara Ann Sparrough</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO <b>None</b>		INFORMANT <b>Mother Barbara Ann Jackson, 5107 Edgewood Rd.,</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Asphyxia</b> DUE TO (c) <b>in the presence of ecchymosis &amp; blood from pericardium</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 25</b> , 19 <b>59</b> , to <b>Dec. 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/1</b> , 19 <b>59</b> , and that death occurred at <b>8:45</b> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas A. Christensen</b>		ADDRESS (Street, city or town, state) <b>6905 Becht Blvd College Park, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen</b>		DATE SIGNED <b>12/1/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/2/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. RECEIVED BY REGISTRAR <b>DEC 5 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4



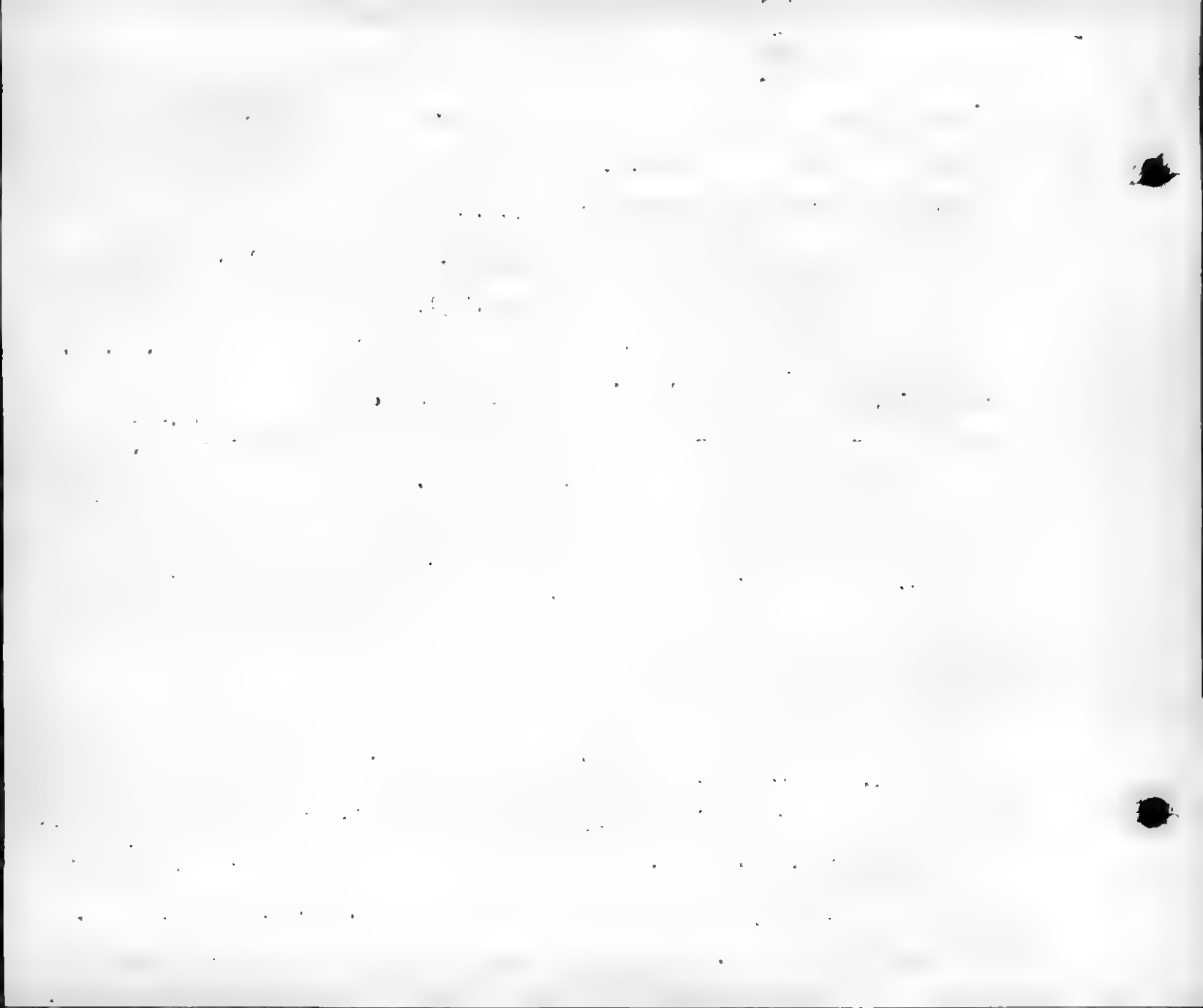
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14057

CERTIFICATE OF DEATH

Reg. Dist. No. 14052

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>P.O. Box 62</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Lee Jett Jr.</b>				4. DATE OF DEATH Month Day Year <b>Dec. 12 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 28, 1959</b>	
9. AGE (In years last birthday) yrs <b>11</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11</b>		11. IF UNDER 24 HRS Hours Min. <b>11</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Lee Jett, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Jo Ann Clendenin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT <b>XXXXX Jo Ann Clendenin</b>		Address <b>Same as above.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>760.5 patchy atelectasis -</b> DUE TO (b) <b>inter-cranial hemorrhage, old</b> DUE TO (c) <b>prematurity (weight 1200 gm L. 41 cm)</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 28, 1959</b> to <b>Dec. 12 1959</b> , that I last saw the deceased alive on <b>Dec. 12, 1959</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William A. Stecker M.D.</b>		ADDRESS (Street, city or town, state) <b>6300 Annapolis Rd. Riverdale, Maryland</b>		DATE SIGNED <b>12/12/59</b>			
PHYSICIAN'S NAME (Type) <b>William A. Stecker M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>				ADDRESS <b>Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 16 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14058

14058

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ADSACORTDIES REST HOME</u>				d. STREET ADDRESS <u>5510 16th St NW</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>BARTELS</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 13, 1875</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE M ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/10/1959</u> , to <u>12/21/1959</u> , that I last saw the deceased alive on <u>12/20/1959</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4410 74th Ave Washington D.C.</u> DATE SIGNED <u>12/21/59</u> ACTUAL SIGNATURE <u>F. F. Musser</u> M.D. <u>  </u> PHYSICIAN'S NAME (Type) <u>F. F. Musser</u> <u>L. L. Jones, M.D.</u>							
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		22b. DATE THEREOF <u>12-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heath Funeral Home</u>				ADDRESS <u>4812 Ga. Ave Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,7,12 - Film 24-17-1-60-1b

## CERTIFICATE OF DEATH

Items 8,9,13,14 - Film 24-17-1-60-1b

Reg. Dist. No.

14054

14059

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dorsey Road SE</i>		c. LENGTH OF STAY IN 1b		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Washington, D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Truman George County Rest Home</i>				d. STREET ADDRESS <i>St. John's Catholic Church</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Johnson</i> Last <i>Johnson</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>27</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown</i>	9. AGE (In years last birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months <i>75</i> Days <i>75</i> Hours <i>75</i> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cleaning</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown ??</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Hospital Records</i> Address <i>Dorsey Rd., Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute non specific Colitis</i> DUE TO (b) <i>General Arteriosclerosis (senile)</i> DUE TO (c) <i>unknown</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>natural causes</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>natural causes</i>			
20c. TIME OF INJURY Month <i>Sept</i> Day <i>1</i> Year <i>1959</i> Hour <i>11</i> a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5440 Silver Hill Rd SE</i>	
20f. (City or town) <i>Washington</i>				20g. (County) <i>D.C.</i>		20h. (State) <i>D.C.</i>	
21. I certify that I attended the deceased from <i>Sept 1</i> , 19 <i>59</i> , to <i>Dec 27</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Dec 26</i> , 19 <i>59</i> , and that death occurred at <i>4:30</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5440 Silver Hill Rd SE</i> DATE SIGNED <i>Paul C. Tanatta</i>							
ACTUAL SIGNATURE <i>Paul C. Tanatta</i> M.D. <i>Washington D.C.</i>							
PHYSICIAN'S NAME (Type) <i>PAUL C. TAN ATTA</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-30-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. John</i>		22d. LOCATION (City, town, or county) (State) <i>Clinton Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thylla K. Sullivan</i>				ADDRESS <i>H 339 New Pl., N.E.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 31 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Clara S. Kenna</i>			



CERTIFICATE OF DEATH

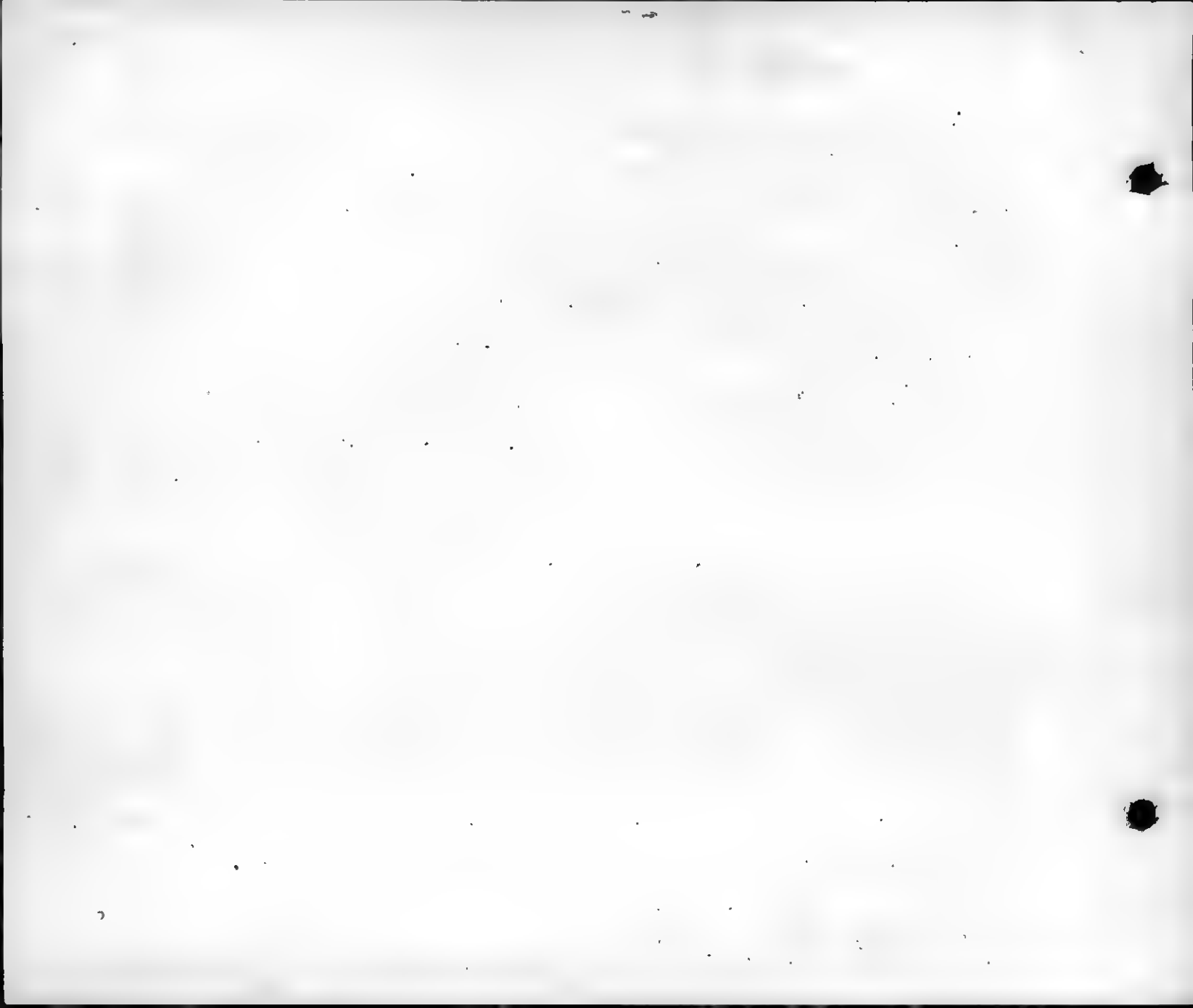
Reg. Dist. No.

14013

14055

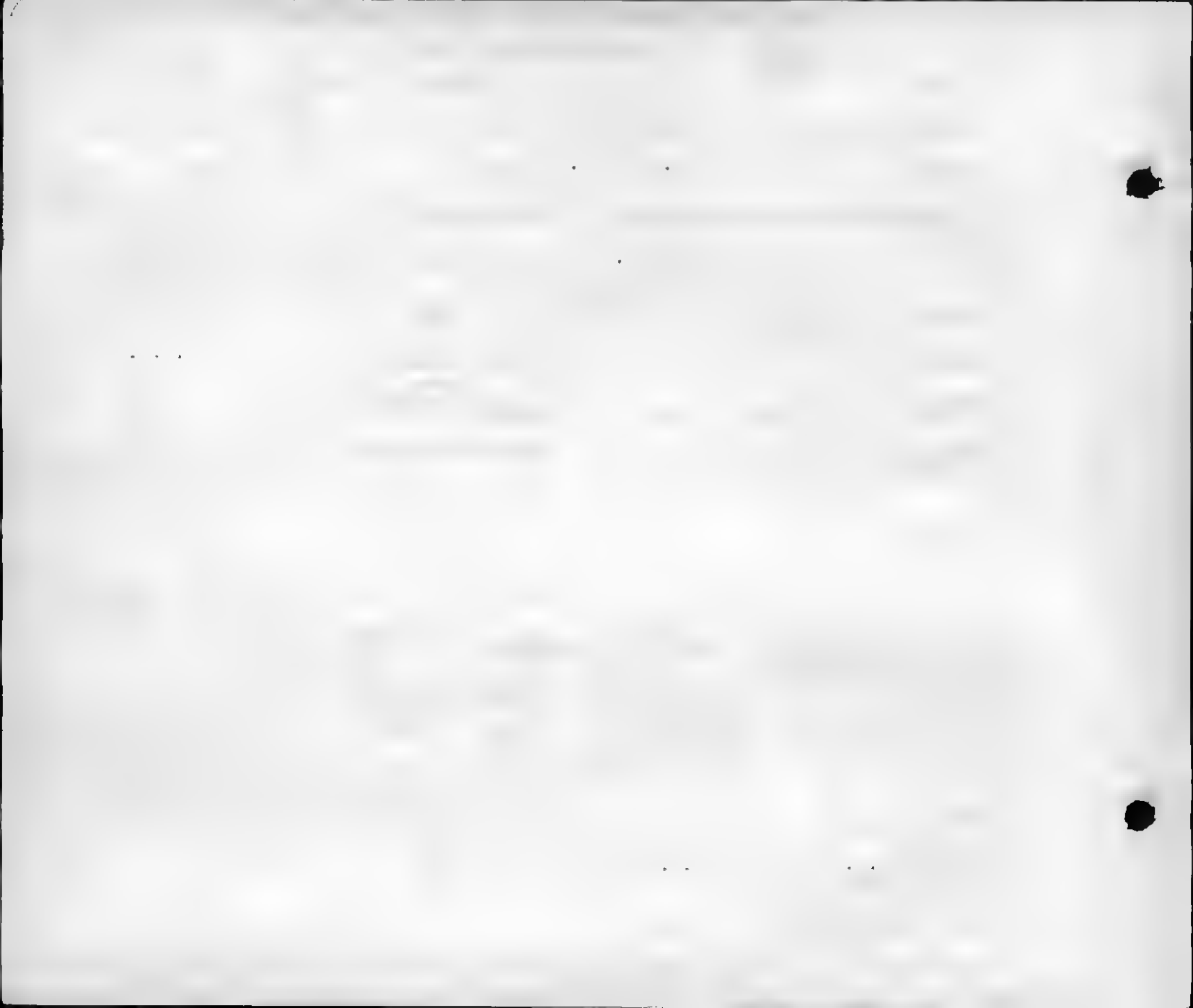
1. PLACE OF DEATH a. COUNTY <b>PRINCE George</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. COUNTY <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN lb <b>2 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>1761 MASS. AVE. N.W.</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ETTA VIOLA Johnson</b>				4. DATE OF DEATH Month Day Year <b>Dec 28 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>Oct. 3 - 1974</b>	
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILLINERY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, MD, USA</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, MD, USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>FRANKLIN A Neale</b>				14. MOTHER'S MAIDEN NAME <b>HANNAH L. Salje</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>SR. Insurance, Theresa CARROLL, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS C MYOCARDIAL INFARCTION</b> 585 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHOLECYSTITIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 months</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>MAR 26 1958</b> to <b>DEC 28 1959</b> , that I last saw the deceased alive on <b>DEC 27 1959</b> , and that death occurred at <b>7 A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>322 H ST NE</b> DATE SIGNED <b>12/28/59</b> ACTUAL SIGNATURE <b>Thomas F Collins</b> M.D. PHYSICIAN'S NAME (Type) <b>THOMAS F COLLINS MD</b> <b>322- H ST NE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>Ellsworth Armacost-4600 Liberty Hgts. Ave.</b>				24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.



## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

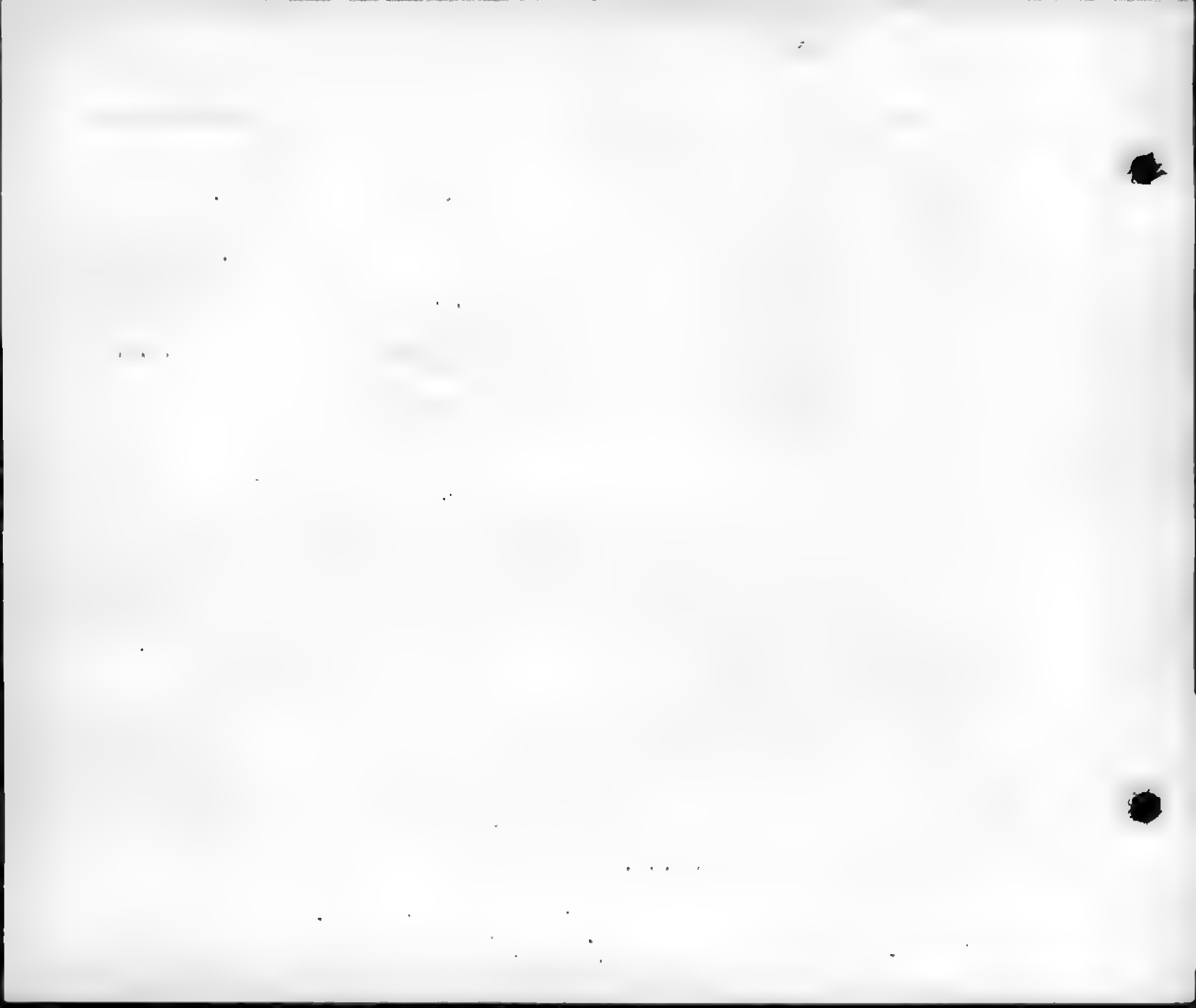
14061

CERTIFICATE OF DEATH

14038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Annapolis</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 Dec. 1959</b>
9. AGE (In years last birthday) yrs. <b>6</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Micheal E=</b>		14. MOTHER'S MAIDEN NAME <b>Beryl J MARSHIO</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>7725</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO (b) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 Dec. 1959</b> to <b>7 Dec. 1959</b> , that I last saw the deceased alive on <b>7 Dec. 1959</b> , and that death occurred at <b>3,30A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William K Greco</b> M.D.		ADDRESS (Street, city or town, state) <b>8303 Rantle Lane</b> DATE SIGNED <b>12/8/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. William Greco, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>12/9/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital</b>	22d. LOCATION (City, town, or county) (State) <b>Cheverly Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W Penn Jr</b> ADDRESS <b>Administrator.</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14037

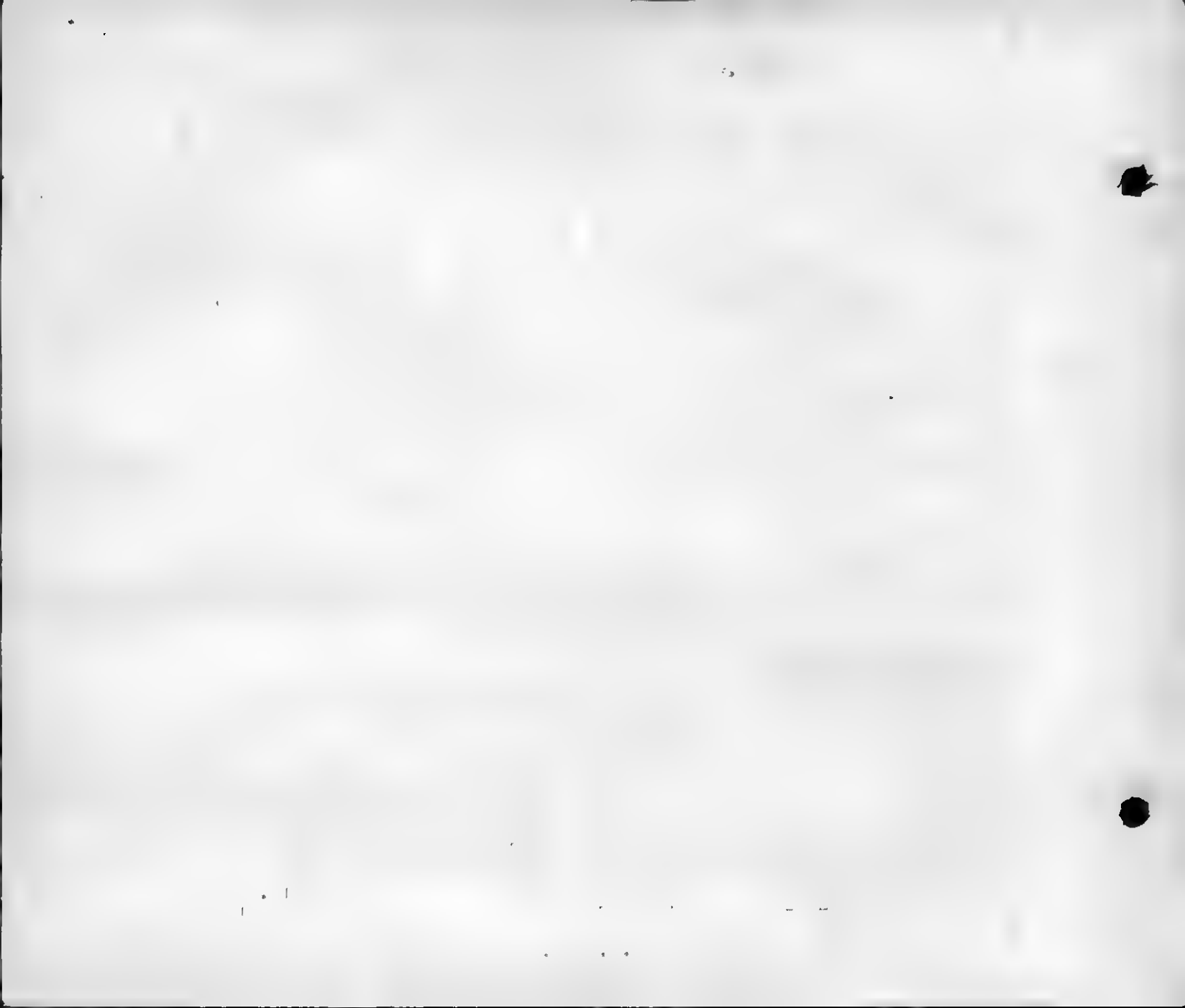
24107

1. PLACE OF DEATH o COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 5 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, DC				d. STREET ADDRESS 1633 MORRIS ROAD, SE			
d. NAME OF HOSPITAL (If not in hospital, give street address) USAF HOSPITAL ANDREWS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ANTHONY L JONES				4. DATE OF DEATH Month Day Year DECEMBER 9 19 59			
5. SEX MALE		6. COLOR OR RACE NEGROID		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 NOVEMBER 1959	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 8		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES							
13. FATHER'S NAME JARVIS J. JONES				14. MOTHER'S MAIDEN NAME ARDELLE L LAURENCE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) N/A		17. INFORMANT FATHER		Address SAME AS 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Diarrhea DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 19 hrs. 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 1 Dec, 1959, to 2 Dec, 1959, that I last saw the deceased alive on 2 Dec, 1959, and that death occurred at 1130 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Vincent P Ringrose, Jr. M.D.				USAF HOSPITAL ANDREWS 9 DECEMBER 1959			
PHYSICIAN'S NAME (Type) VINCENT P RINGROSE, JR, CAPT, USAF, MS USAF HOSPITAL ANDREWS, WASHINGTON 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-12-59		22c. NAME OF CEMETERY OR CREMATORY PLEASANT PLAINS		22d. LOCATION (City, town, or county) (State) AHOSSKIE, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE B. F. Taylor, 1702 12TH ST, N.W. D.C.				24a. REC'D BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1243XV4



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14030

Reg. Dist. No.

14014

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			c. LENGTH OF STAY IN 1b <b>8 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1100 Oglethorpe Street</b>				d. STREET ADDRESS <b>1100 Oglethorpe Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Frank</b> Middle <b>Jacob</b> Last <b>Kiess</b>				<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>1,</b> Year <b>19 59</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-26-88</b>		<b>9. AGE</b> (In years last birthday) <b>71</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Printing</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Kiess</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ellen L. Fehr</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>W.W.1 577-10-8789A</b>		<b>17. INFORMANT</b> Address <b>Ellen S. Kiess; same address as # 2.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>December 2, 1959</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12/3/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Ft Lincoln Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Colmar Manor, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>R. Gasch's Sons Hyattsville Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE DEC 4 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harris</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

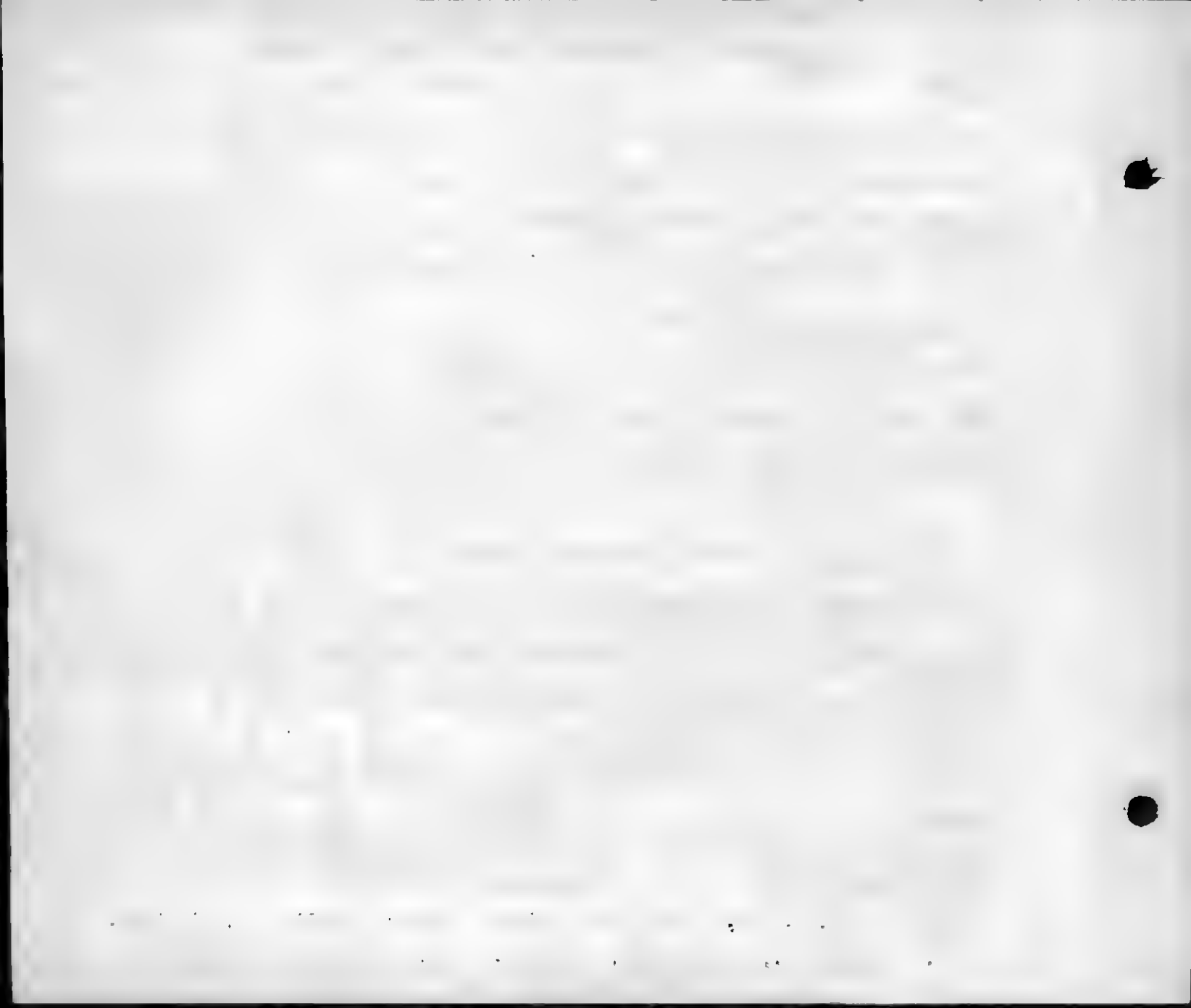
14062

14040

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. LENGTH OF STAY IN TB <u>Deadman's</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>11822-59th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Lee</u> Last <u>King</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 21, 1925</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Westchester, Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Rufus King</u>				14. MOTHER'S MAIDEN NAME <u>Laurel Ethel Walton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>579-10-5498</u>		17. INFORMANT <u>Helen M. Brady</u> Address <u>Upper Meriden</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock</u> 716.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Universal burns of body, second degree</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was sleeping in room that caught on fire</u>					
20c. TIME OF INJURY Month, Day, Year <u>3:00 p.m.</u> <u>12-14-1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Capitol Heights, B.</u>	(County) <u>  </u>	(State) <u>  </u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Vinspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Samuel S. T. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec 19, 1959</u>			
22a. BURIAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 23, 1959</u>		22c. NAME OF CEMETERY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u>				ADDRESS <u>Riverdale, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





14063

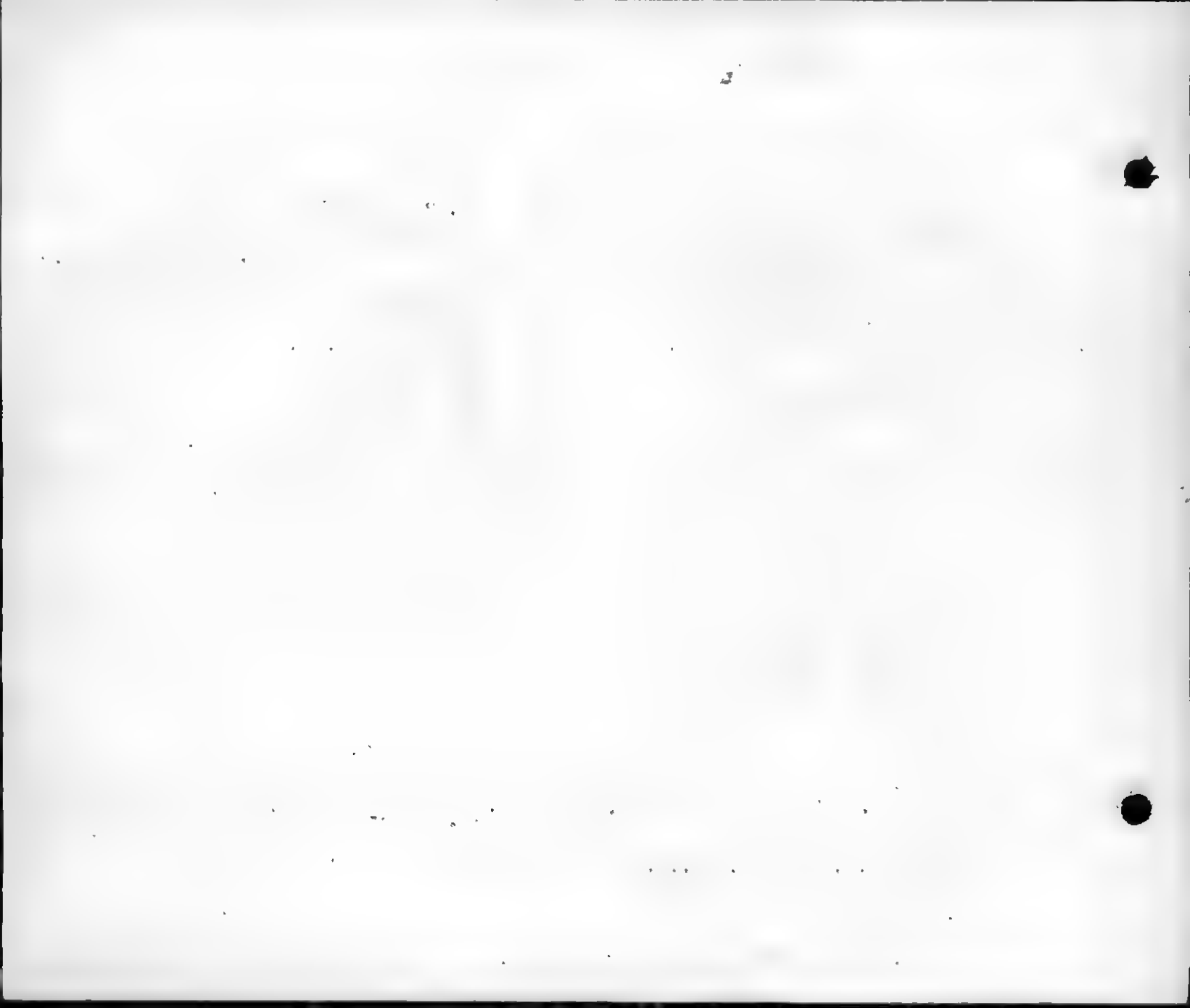
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>P.O. Box Box 366</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Betty= Pauline Knauer</b>				4. DATE OF DEATH Month Day Year <b>Dec. 8 8 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June 1938</b>		9. AGE (In years last birthday) yrs. <b>21</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Herman Knauer</b>				14. MOTHER'S MAIDEN NAME <b>Ruth B Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Herman Knauer Beltsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Masses left untreated. Secondary</b> <b>414X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Sub acute Sactinal endocarditis</b> DUE TO (c) <b>Rheumatic Heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>59</b> , to <b>DEC</b> , 19 <b>59</b> , that I lost saw the deceased alive on <b>DEC 8</b> , 19 <b>59</b> , and that death occurred at <b>7:40A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4713 Berwyn Rd College Park Md</b> DATE SIGNED <b>12/8/59</b>							
ACTUAL SIGNATURE <b>Dr. W. Etienne</b>		M.D. <b>4713 Berwyn Rd College Park Md</b>					
PHYSICIAN'S NAME (Type) <b>Dr. W. Etienne, Md.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bowie Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Harris</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

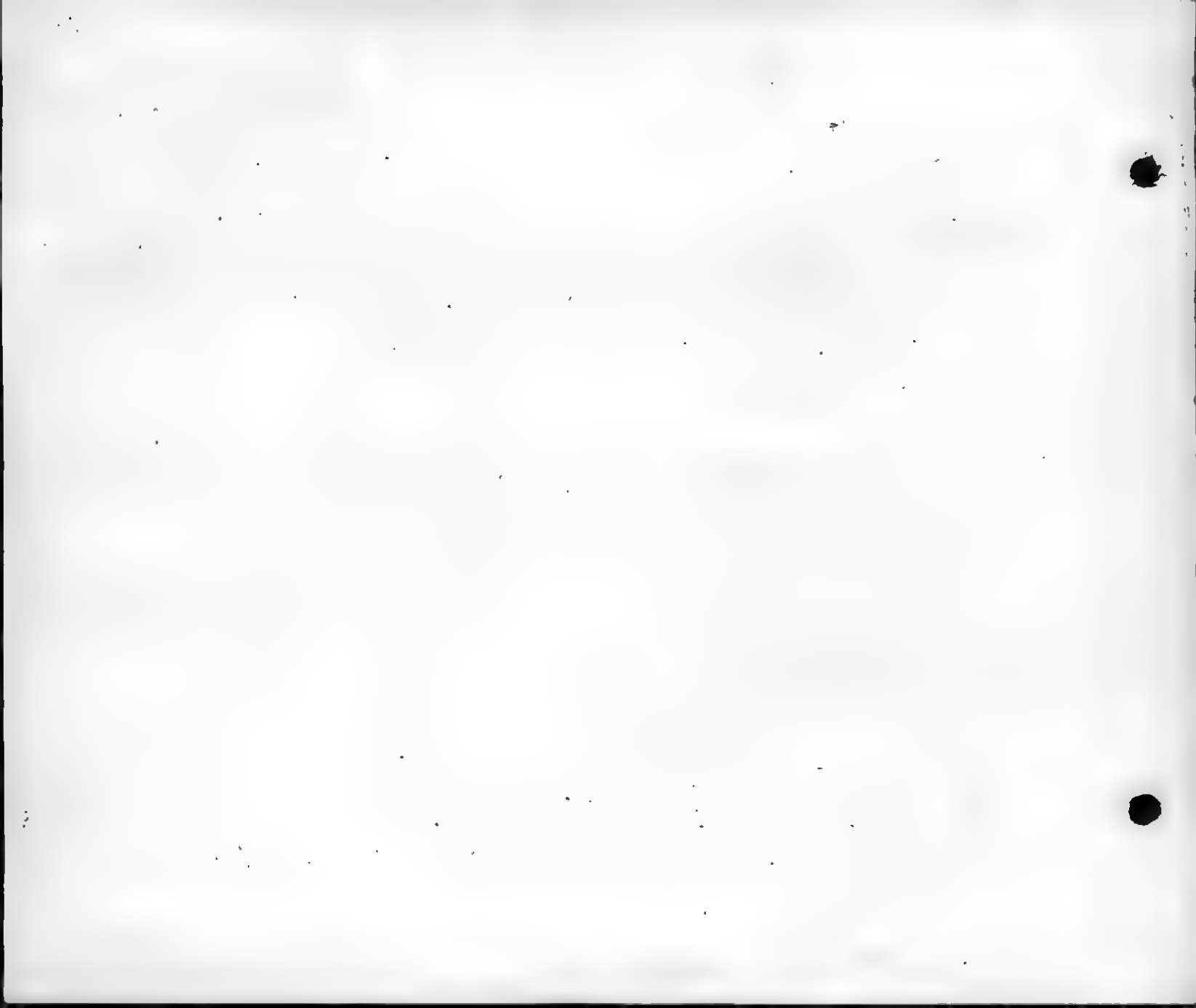
Reg. Dist. No.

14064

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg Md.</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4101 55th avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>33 Bladensburg Md.</b>	
f. STREET ADDRESS <b>4101 55th avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>A.</b> Last <b>KNEFELY</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JAN 3, 1889</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer Forman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>University of Md</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Knafely</b>		14. MOTHER'S MAIDEN NAME <b>Mary E Leighsier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mildred K Belvin Bladensburg Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Hypertensive Cardiovascular Disease</b> 445X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>Dec 25</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec 23</b> , 19 <b>59</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D Rosson</b> M.D.		ADDRESS (Street, city or town, state) <b>5304 ANNAPOLIS ROAD</b> DATE SIGNED <b>12/25/59</b>	
PHYSICIAN'S NAME (Type) <b>William D. Rosson</b>		<b>BLADENSBURG, MARYLAND.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 28, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

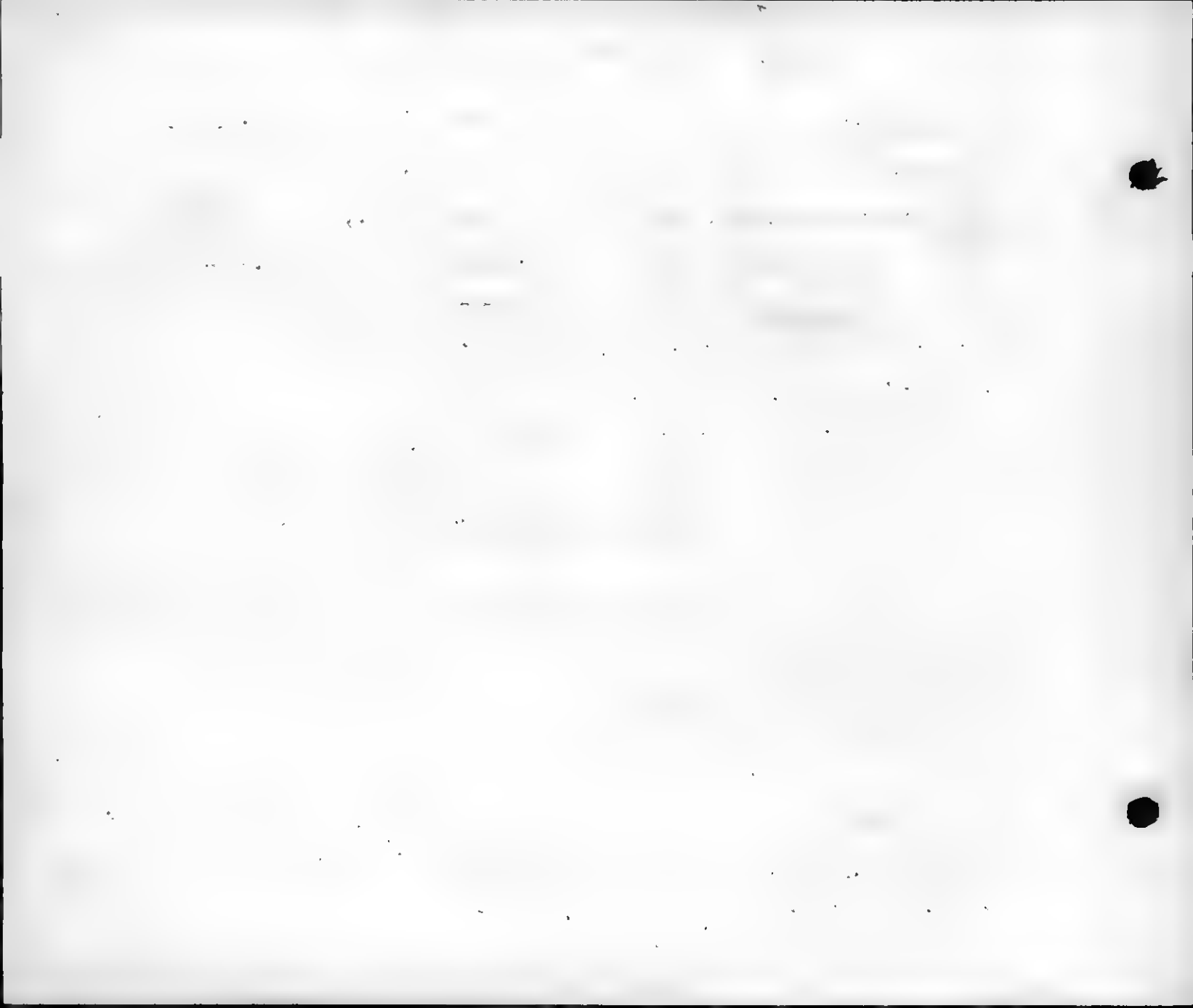
14065

CERTIFICATE OF DEATH

Reg. Dist. No.

14371

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>34 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> d. STREET ADDRESS <b>6208 I St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>T.</b> Last <b>Kreuter</b>		4. DATE OF DEATH Month <b>12-30-</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-01</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILWAY EXPRESS</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES KREUTER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>SARAH L. KREUTER</b>		Address <b>HILLSIDE, MD.</b> <b>6208 I ST.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Sumo pneumonia -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO <b>AF de</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-26</b> , 19 <b>58</b> , to <b>Dec 30 1958</b> that I last saw the deceased alive on <b>Dec 30 1958</b> , and that death occurred at <b>3:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leon Levitsky</b>		ADDRESS (Street, city or town, state) <b>2408 RODE ISLAND AVE</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Leon Levitsky</b>		DATE SIGNED <b>12/31/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/2/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WASH NATL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>SUITLAND B. PR. 6006, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>	
ADDRESS <b>517-11 ST SE WASH. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

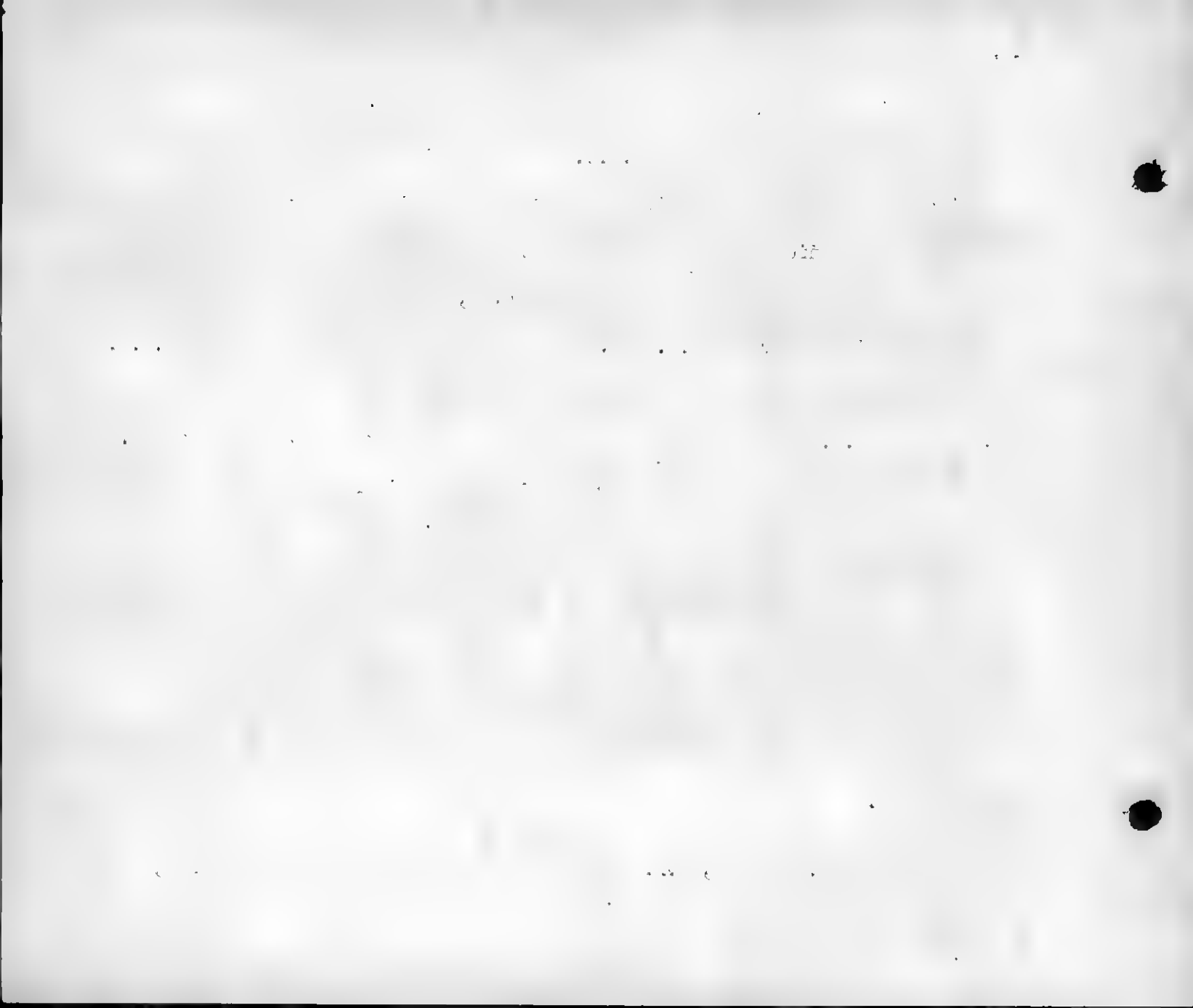
14043

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>96 Kingston Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <b>Johmie</b></span> <span>Middle <b>Radford</b></span> <span>Last <b>Lane</b></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <b>December</b></span> <span>Day <b>4</b></span> <span>Year <b>1959</b></span> </div>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 8, 1914</b>	
<b>9. AGE</b> (In years last birthday) <b>44</b> yrs		<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>11</b>		<b>IF UNDER 24 HRS.</b> Hours <b>11</b> Min. <b>15</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Electronic inspector</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Govt.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Texas</b>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>CHARLES LANE</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ERTA NICTOLS</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>U.S.N</b>		<b>17. INFORMANT</b> <b>Mary Anna Lane; same address as # 2.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <b>Acute congestive heart failure</b>  <b>442X</b>  <b>DUE TO</b>  <b>Cardiovascular renal disease</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b>  <b>DUE TO</b>  <b>(c)</b> </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>			<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		
<b>20f. (City or town)</b>			<b>(County)</b>		<b>(State)</b>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> 				<b>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>		<b>DATE SIGNED</b> <b>December 4, 1959</b>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			
<b>22b. DATE THEREOF</b> <b>12-8-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mary's</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Annapolis, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> 				<b>ADDRESS</b> <b>John S. Connolly 418 Eastern Blvd.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE DEC 8 '59</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> 							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





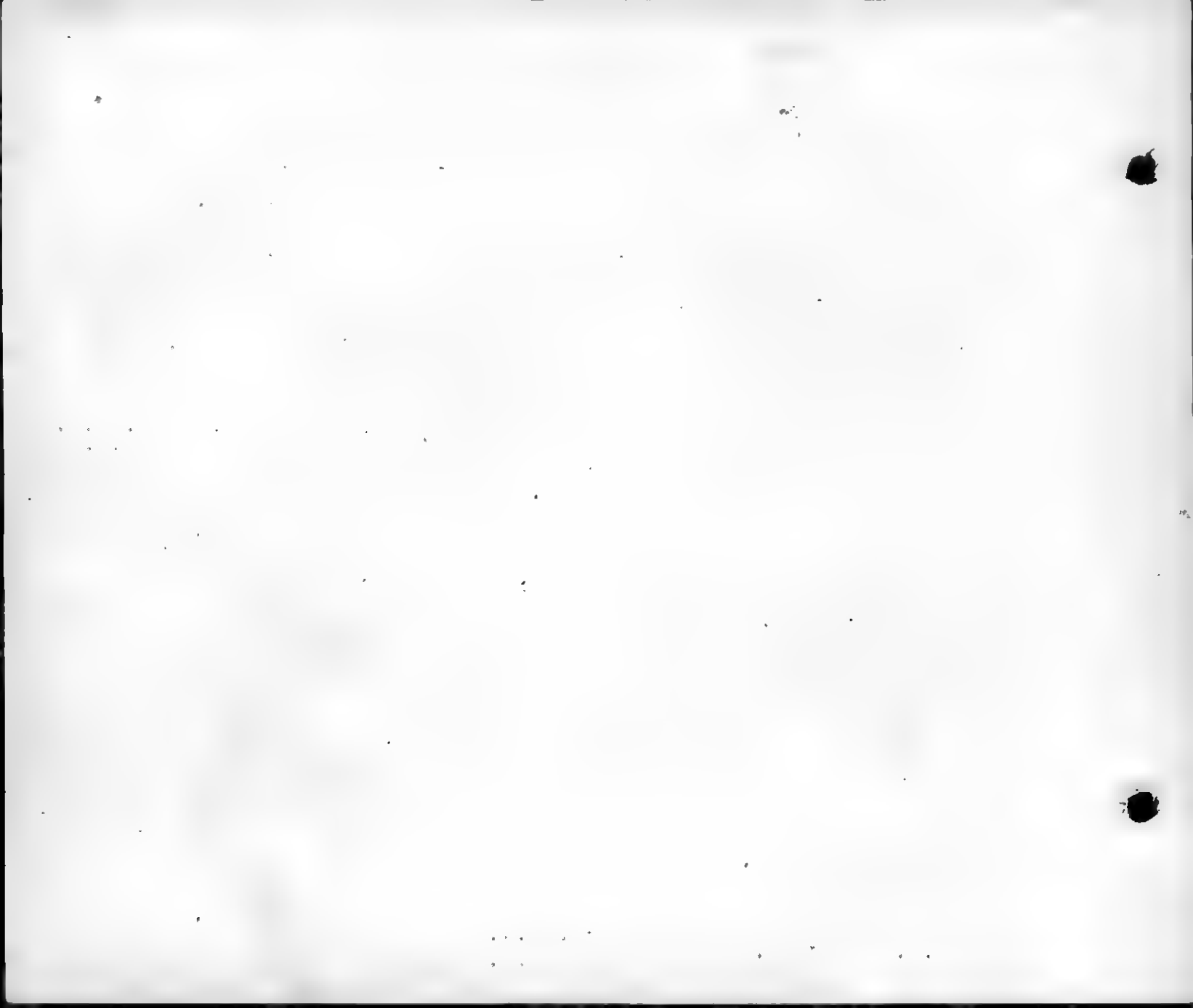
14015

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor		d. STREET ADDRESS 5521 Colorado Ave. N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth S. Leahy		4. DATE OF DEATH Month Day Year Dec. 12, 1959 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/89
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Massachusetts	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Sullivan		14. MOTHER'S MAIDEN NAME Katherine Cuddihy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) no		16. SOCIAL SECURITY NO. 226-38-8904	
17. INFORMANT David E. Leahy		Address 6101 16th St. N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4500 DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm Rt. Temporal Artery (c) Arteriosclerosis DUE TO 5 yrs. 10 yrs.			INTERVAL BETWEEN ONSET AND DEATH 18 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 1951 to DEC 12, 1959 that I last saw the deceased alive on DEC 12, 1959, and that death occurred at 11 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 5315-16th St. N.W. 12/13/59 Wash D.C.			
ACTUAL SIGNATURE Francis T. Coleman M.D.		PHYSICIAN'S NAME (Type) Francis T. Coleman	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/15/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE DEC 16 '59	24b. REGISTRAR'S SIGNATURE Charles S. Hines

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 4 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14 Film G254 1-13-60 et

14067

CERTIFICATE OF DEATH

Reg. Dist. No.

14045

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>2 1/2 Hr.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> d. STREET ADDRESS <b>6309 Muirkirk Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lyle</b> Middle <b>Lesane</b> Last <b>Lesane</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-59</b>
9. AGE (In years last birthday) yrs. <b>3</b> Months <b>6</b> Days <b>6</b> Hours <b>Min.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Solomon Lesane</b>		14. MOTHER'S MAIDEN NAME <b>Helen Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia R. &amp; Embolism</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause-(a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 6</b> , 19 <b>59</b> , to <b>Dec. 6</b> , 1959, that I last saw the deceased alive on <b>Dec. 6</b> , 19 <b>59</b> , and that death occurred <b>2:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. L. ETIENNE</b> M.D. <b>4713 Broadway St.</b> DATE SIGNED <b>12/14/59</b> PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE College Park, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-12-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>New Harmony</b>		22d. LOCATION (City, town or county) (State) <b>md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frazier's Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>	
ADDRESS <b>389 Philadelphia Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

Birth certificate filed 9/3/59 under  
style Donald Marshall.

(Mother gave different information on  
each admission to the hospital)

14019

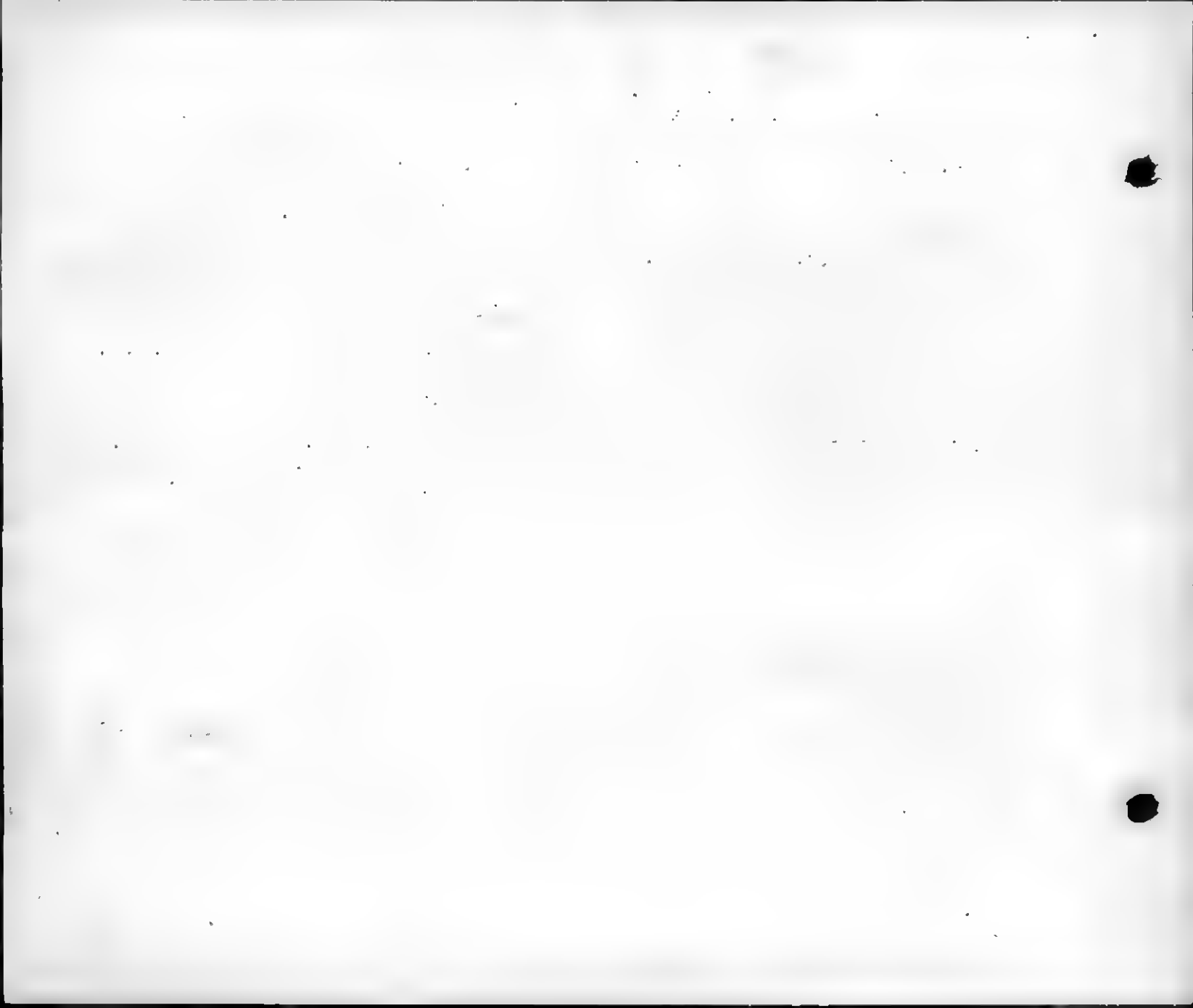
## CERTIFICATE OF DEATH

Reg. Dist. No.

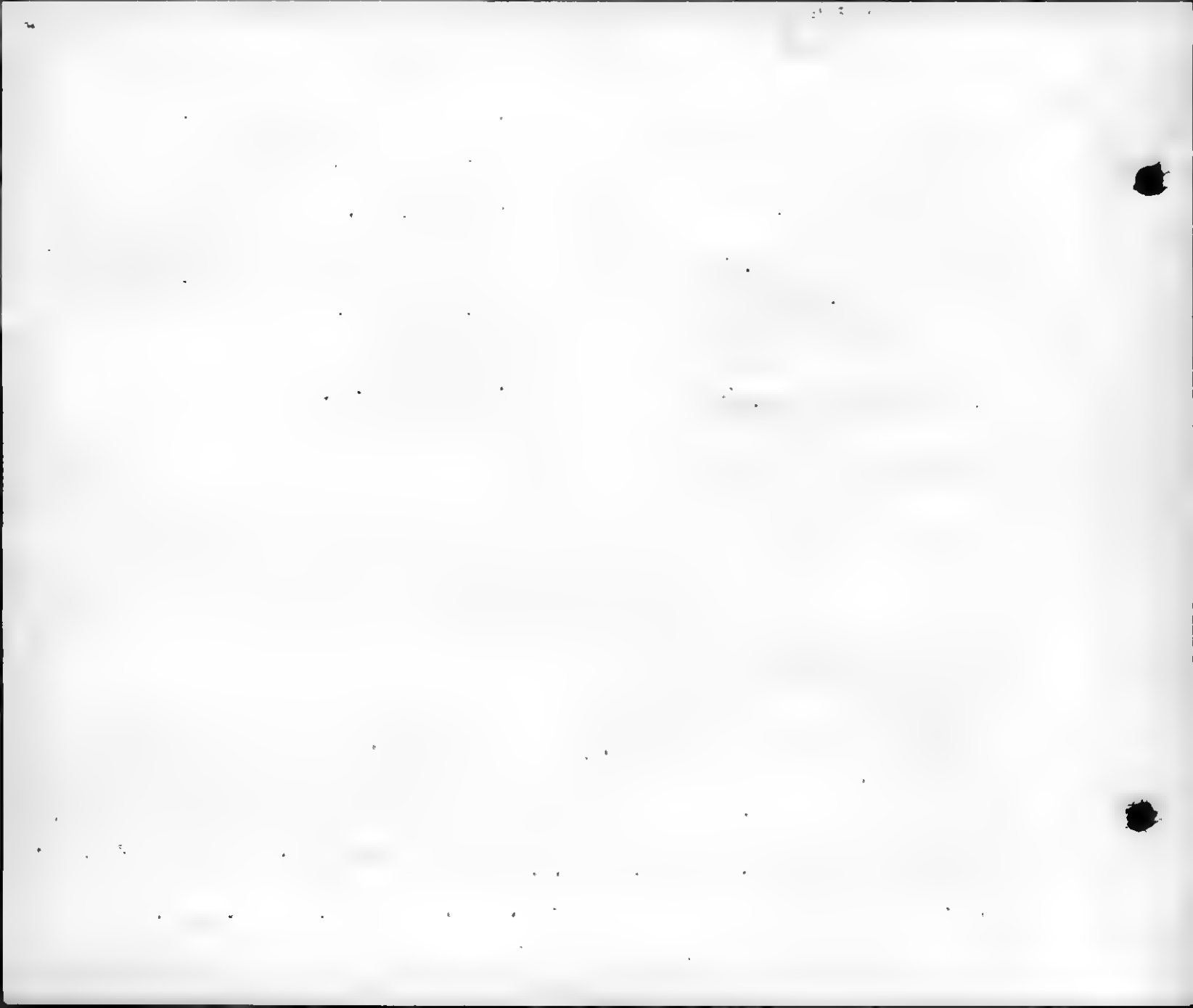
1. PLACE OF DEATH Prince Georges Co. 4303 Russell Ave. Mt. Rainier MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	c. LENGTH OF STAY IN 1b Unknown	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 4303 Russell Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANK W. LOEFFLER		4. DATE OF DEATH Month Day Year Dec. 2. 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-1894
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheetmetal Worker		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Hanover, Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilhelm Loeffler	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no -----	
16. SOCIAL SECURITY NO. 578 09 0272		INFORMANT Address Emmy Loeffler, 4303 Russell Ave. Mt. Rainier, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach (Inoperable)</u> 1. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 3, 1959, to Dec. 2, 1959, that I last saw the deceased alive on Nov. 14, 1959, and that death occurred at 3:40 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED HUGO EINSTEIN M.D. 2021 G St. N.W. Dec. 2, 59			
ACTUAL SIGNATURE HUGO EINSTEIN		PHYSICIAN'S NAME (Type) HUGO EINSTEIN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12-5-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulsen Sons, 1756 P St. N.W. D.C.		24a. REC'D BY REGISTRAR DATE DEC 7 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hearn

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS A15 (4)  
ISM 9/5B





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

14069

## CERTIFICATE OF DEATH

Reg. Dist. No.

14048

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>13X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>				d. STREET ADDRESS <b>Simpsonville</b>			
3. NAME OF DECEASED (Type or print) First <b>Racheal</b> Middle <b>Mac</b> Last <b>rill</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 25, 1881</b>	
9. AGE (In years last birthday) <b>78 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>At home</b>		13. FATHER'S NAME <b>John B. Clarke</b>		14. MOTHER'S MAIDEN NAME <b>Susan <del>Clarke</del> Dorsey Owings</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordis Failure</b> DUE TO <b>2705</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Interferential obstruction Diabetes</b> DUE TO <b>2 weeks</b> (c) <b>Interferential obstruction Diabetes</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>11-27</b> , 19 <b>59</b> , to <b>12-2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-2</b> , 19 <b>59</b> , and that death occurred at <b>11 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>305 Prince George Street, Laurel, Maryland</b> DATE SIGNED <b>12/3/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-4-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>				22d. LOCATION (City, town, or county) (State) <b>Ellicott City Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>							



14108  
CERTIFICATE OF DEATH

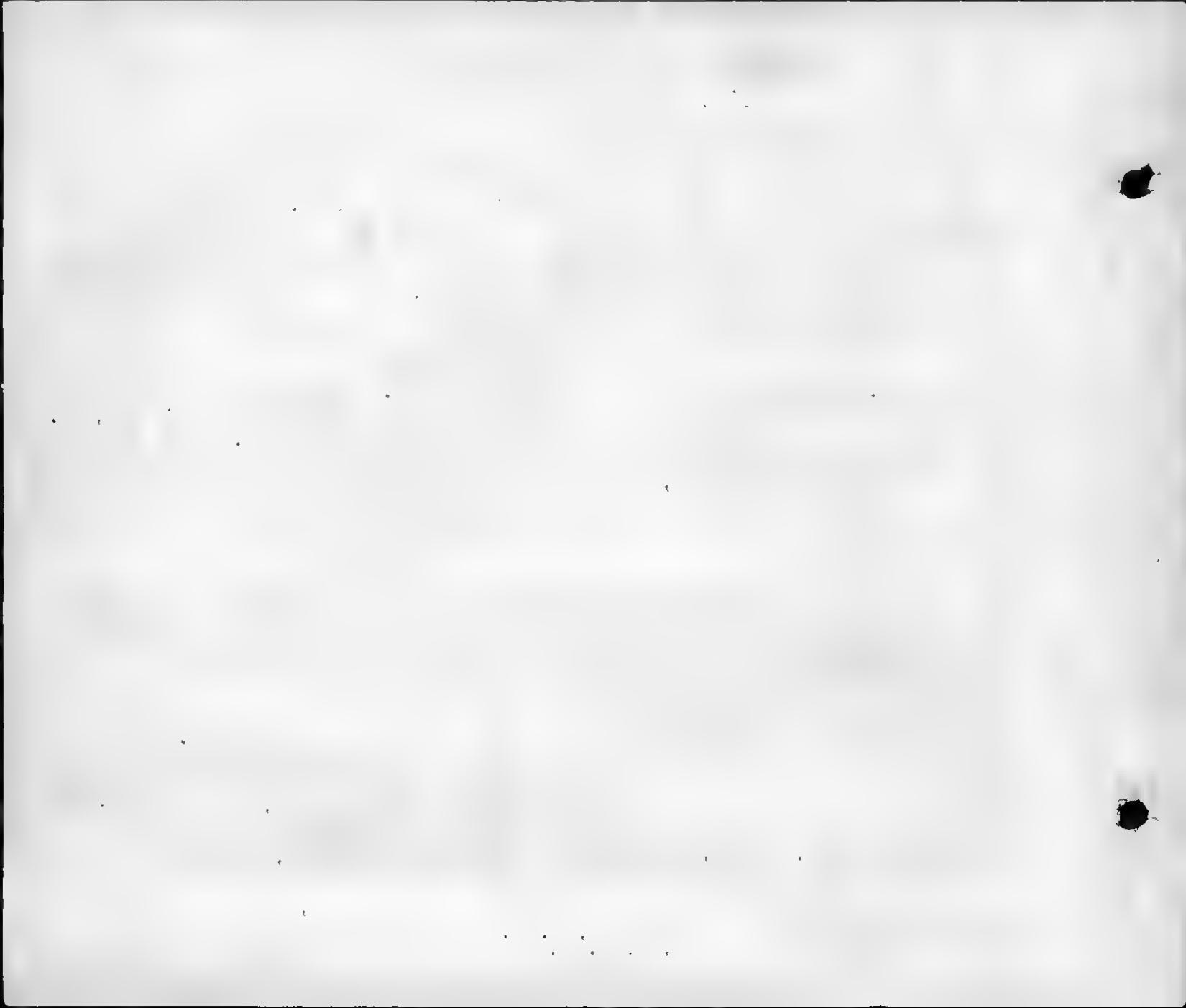
Reg. Dist. No.

14108

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE COUNTY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>			
c. LENGTH OF STAY IN 1b <b>3 Months</b>				d. STREET ADDRESS <b>3134 Parkway Terr. Dr. Apt #6</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>GARRET</b> Last <b>MADDEN</b>				4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 September 1959</b>	
9. AGE (In years last birthday) <b>3</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Prince George County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13. FATHER'S NAME <b>James D. Madden</b>				14. MOTHER'S MAIDEN NAME <b>Constance W. SCHROEDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>N/A</b>		17. INFORMANT <b>Father 3134 Parkway Derr Dr. Apt 6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown, pending Autopsy Report</b> <b>493 X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b></b> Day <b>19</b> Hour <b></b> a. m. <b></b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. [City or town] (County) (State)				20g. [City or town] (County) (State)			
21. I certify that I attended the deceased from <b>26 Dec</b> , 19 <b>59</b> , to <b>26 Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>DOA 26 Dec</b> , 19 <b>59</b> , and that death occurred at <b>0841 A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Sanford L. Billet</b> M.D.				USAF Hospital Andrews, <b>26 Dec 59</b>			
PHYSICIAN'S NAME (Type) <b>SANFORD L. BILLET, Capt USAF MC</b>				Andrews Air Force Base Prince George County, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>816 M Street, N. E. Wash. 2, D. C.</b>		22d. LOCATION (City, town, or county) (State) <b>Auburn, New York</b>	
23. REGISTRAR'S SIGNATURE <b>Michael J. Kneale</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

14109

14109

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

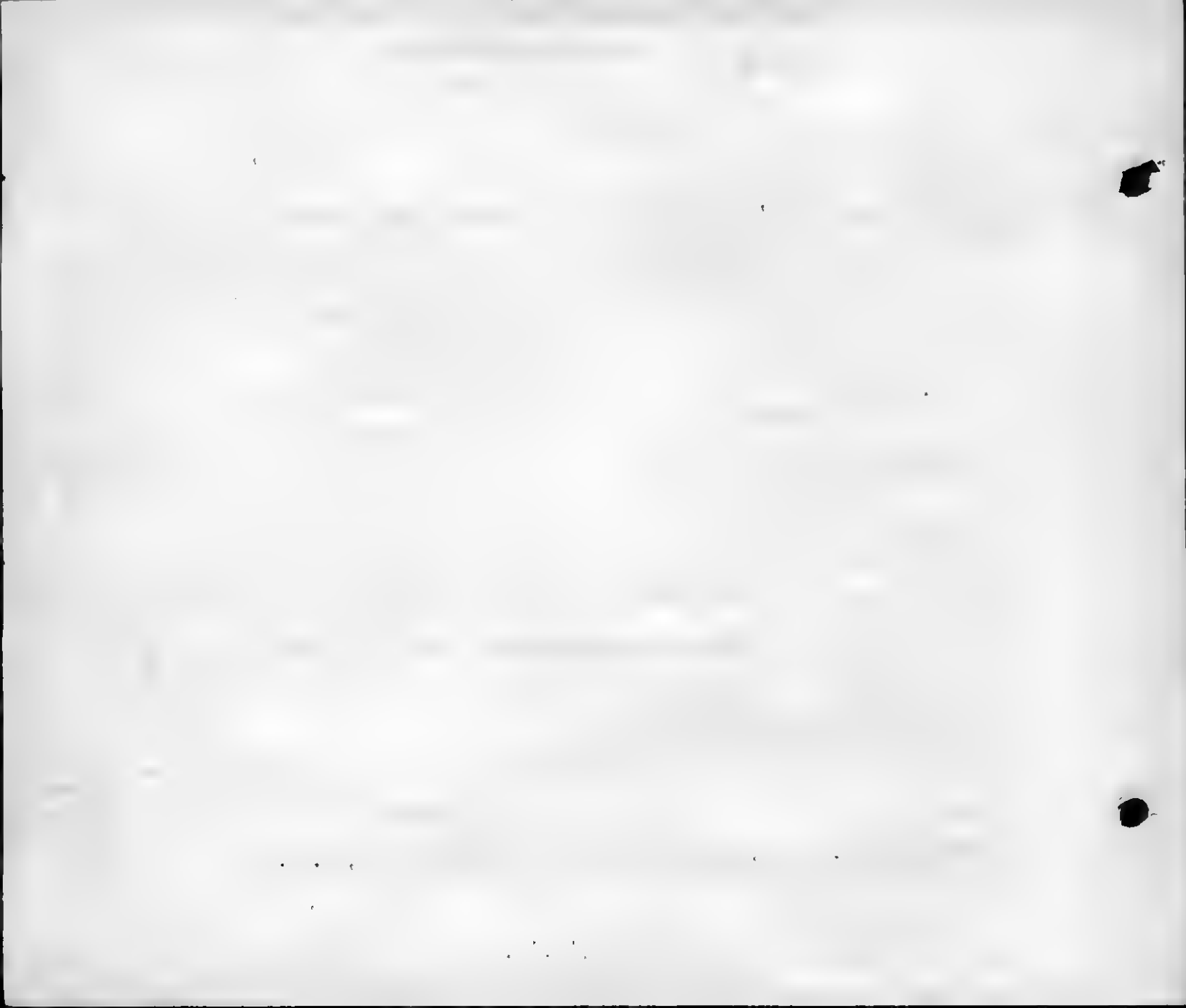
Reg. Dist. No.

14050

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews Air Force Base</b> c. LENGTH OF STAY IN TB <b>USAF Hospital Andrews, Andrews AFB</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital Andrews, Andrews AFB</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE COUNTY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USAF Hospital Andrews, Andrews AFB</b> d. STREET ADDRESS <b>412 60th Avenue, Capitol Heights</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth MALLOY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 December 1959</b>
9. AGE (In years last birthday) <b>9-10</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John X. Malloy</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Jean HARMON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>(Birth Certificate)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MENINGITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Premature birth 4/16 502</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 DEC 1959</b> to <b>26 DEC 1959</b> , that I last saw the deceased alive on <b>26 DEC 1959</b> , and that death occurred at <b>0448 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>John A. Moore</b>		M.D. <b>USAF Hospital Andrews</b> <b>26 Dec 59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN A. MOORE, Capt USAF MC</b>		<b>Andrews Air Force Base</b> <b>Washington 25, D. C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Boston, Massachusetts</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Michael J. Rinaldi</b> <b>Rinaldi Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rinaldi</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

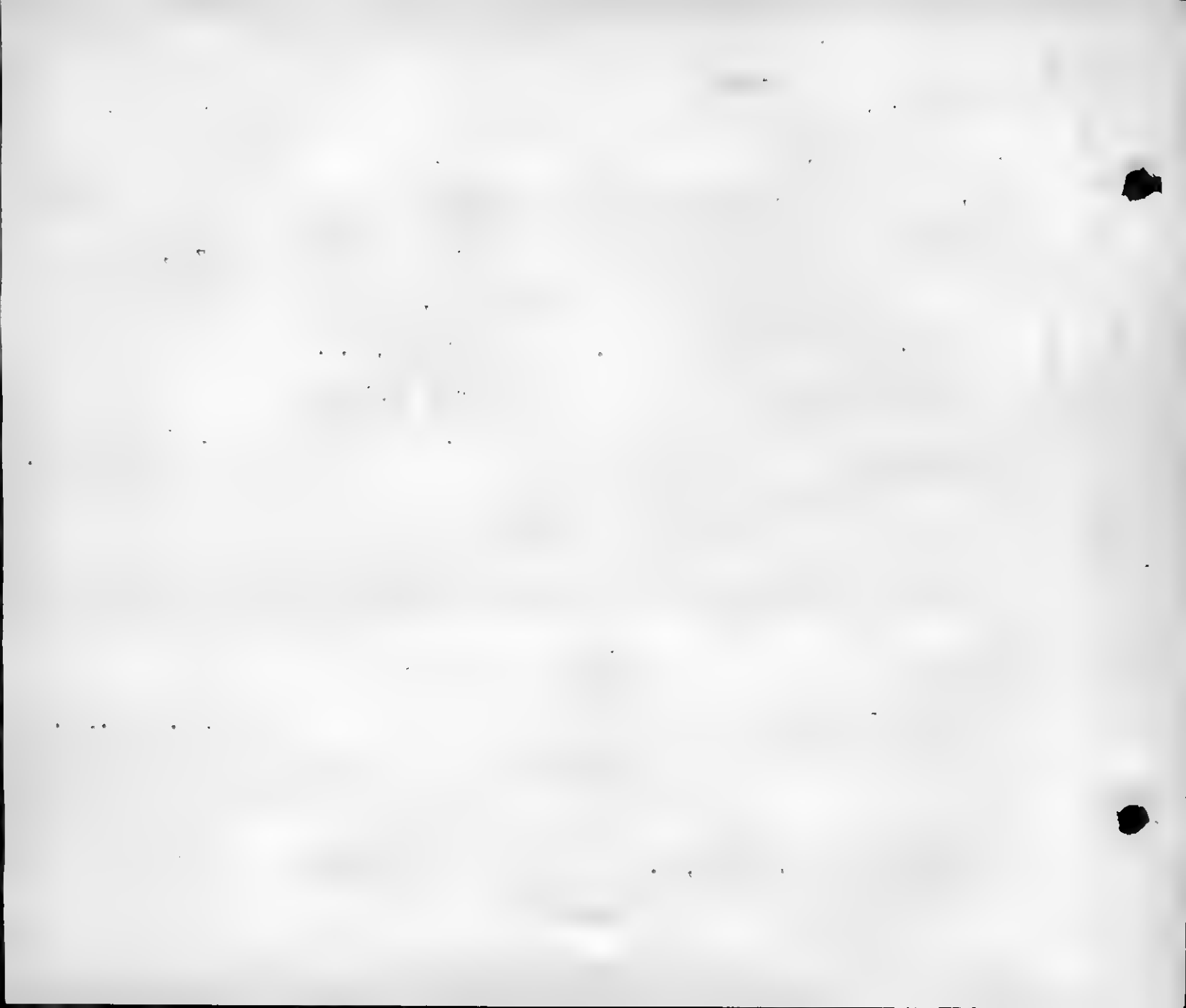
14051

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Tony's Texaco, Junction Route #50 &amp; #301</b>		e. STREET ADDRESS <b>9104 Wallace Road</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>PAUL NATHANIEL MARSHALL</b>		<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>7th</b> , Year <b>19 59</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 14th, 1935</b>
<b>9. AGE</b> (In years last b. rthday) <b>24</b> yrs		<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>School Bldg.</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington, D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Michael Jerome Marshall</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Elsie Marie Smith</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>Korean</b>		<b>16. SOCIAL SECURITY NO</b> <b>Unknown</b>	
<b>17. INFORMANT</b> <b>Michael J. Marshall, Route # 1, Mitchellville, Md.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>Part I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) Hemorrhage &amp; Shock</b> <b>777X</b> <b>DUE TO</b> <b>(b) Gunshot wound of chest</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b> <b>(c)</b>	
<b>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> <b>his attempted</b> <b>Shot during holdup of gas station</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>12:17</b> <b>o. m.</b> <b>12/7/1959</b>		<b>20d. INJURY OCCURRED</b> <b>While</b> <input type="checkbox"/> <b>Not while</b> <input checked="" type="checkbox"/> <b>of work</b>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Place of death</b>		<b>20f. (City or town)</b> (County) (State) <b>Mitchellville, Pr. Geo. Co., Md.</b>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>12-11-59</b>		<b>22b. DATE THEREOF</b> <b>12-11-59</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington 467-14 St. NW</b>		<b>22d. LOCATION (City, town, or County)</b> (State) <b>Washington 467-14 St. NW</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HS Washington 467-14 St. NW</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DEC 14 '59</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>		<b>DATE SIGNED</b> <b>12/7/1959</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, the certificate should be executed within 72 hours after death. If any delay is anticipated, the certificate should be executed within 72 hours after death. If any delay is anticipated, the certificate should be executed within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14052

14111

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1307-Balfour Court</u>		d. STREET ADDRESS <u>1307-Balfour Court</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Paul</u> Middle <u>Mayhew</u> Last		4. DATE OF DEATH <u>12-13</u> Month <u>1959</u> Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigerator dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>meats</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph W. Mayhew</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>579-46-3971</u>	
17. INFORMANT <u>Catherine M. Trevithick</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION (3RD)</u> DUE TO (c) <u>GENERALIZED + CORONARY ARTERIOSCLEROSIS</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>56</u> , to <u>13 DEC.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 DEC.</u> , 19 <u>59</u> , and that death occurred at <u>5:58 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry R. Wolfe</u>		ADDRESS (Street, city or town, state) <u>905 SHERIDAN ST.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE M.D.</u>		DATE SIGNED <u>12/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Riggs Road, Prince Georges Co.</u>		22d. LOCATION (City, town or county) (State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		ADDRESS <u>Mt. Rainier Md</u>	
24. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>		DATE <u>DEC 16 '59</u>	



14112

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>PR. Geo.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5250-Auth Rd.</i>				d. STREET ADDRESS <i>5250-Auth Rd</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARTHA C. S. MAYHugh</i>				4. DATE OF DEATH Month Day Year <i>Dec. 13 1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-28-1874</i>		9. AGE (In years last birthday) <i>85</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>INDIANA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Miles Stratford</i>				14. MOTHER'S MAIDEN NAME <i>Mary Jane - McKay</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <i>Alice M. Dibrell</i>		Address <i>5250-Auth Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> 42. ) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>5 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis, Emphysema</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1, 1949</i> to <i>12-13, 1959</i> , that I last saw the deceased alive on <i>12-13, 1959</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>David S. Gordon</i>				ADDRESS (Street, city or town, state) <i>5731 23rd Parkway SE</i>		DATE SIGNED <i>12-13-59</i>	
PHYSICIAN'S NAME (Type) <i>DAVID S. GORDON, M.D.</i>							
22a. MANNER, CREMATION, REBURYAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>12-14-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Eden Hill Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Southland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samson Bros Funeral Home</i>				ADDRESS <i>1611- Good Hope Rd SE</i>		24a. REG'D BY REGISTRAR <i>DEC 16 59</i>	
						24b. REGISTRAR'S SIGNATURE <i>William S. Thayer</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 4 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No

14113

1. PLACE OF DEATH a. COUNTY <i>Prince Geo's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine, md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>---</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Roderic Paul Meinhardt</i>		4. DATE OF DEATH Month Day Year <i>December 2 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 21, 1959</i>
9. AGE (In years last birthday) yrs. <i>7</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>---</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Theodore Meinhardt</i>		14. MOTHER'S MAIDEN NAME <i>Marilyn Ruth Ely</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>---</i>	
17. INFORMANT <i>Theodore Meinhardt-Same as above.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>500x</i> DUE TO <i>Asphyx</i> <i>Suffocation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute Toxic Shock Syndrome</i> DUE TO <i>Infection</i> (c) <i>Infection</i>		INTERVAL BETWEEN ONSET AND DEATH <i>minimal</i> <i>2 Days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12-2</i> , 19 <i>59</i> to <i>12-2</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-2</i> , 19 <i>59</i> , and that death occurred at <i>5:35 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Brandywine, md Dec. 2, 59</i>			
ACTUAL SIGNATURE <i>Ritchie Bros.</i> M.D.		DATE SIGNED <i>Dec. 2, 59</i>	
PHYSICIAN'S NAME (Type) <i>Richard Ho Dobson</i>		<i>Brandywine, md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/4/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cheltenham Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cheltenham, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros. Funeral Home-Marlboro, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 7 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

206,2-4507

St Mary's  
Charles

## CERTIFICATE OF DEATH

Reg. Dist. No.

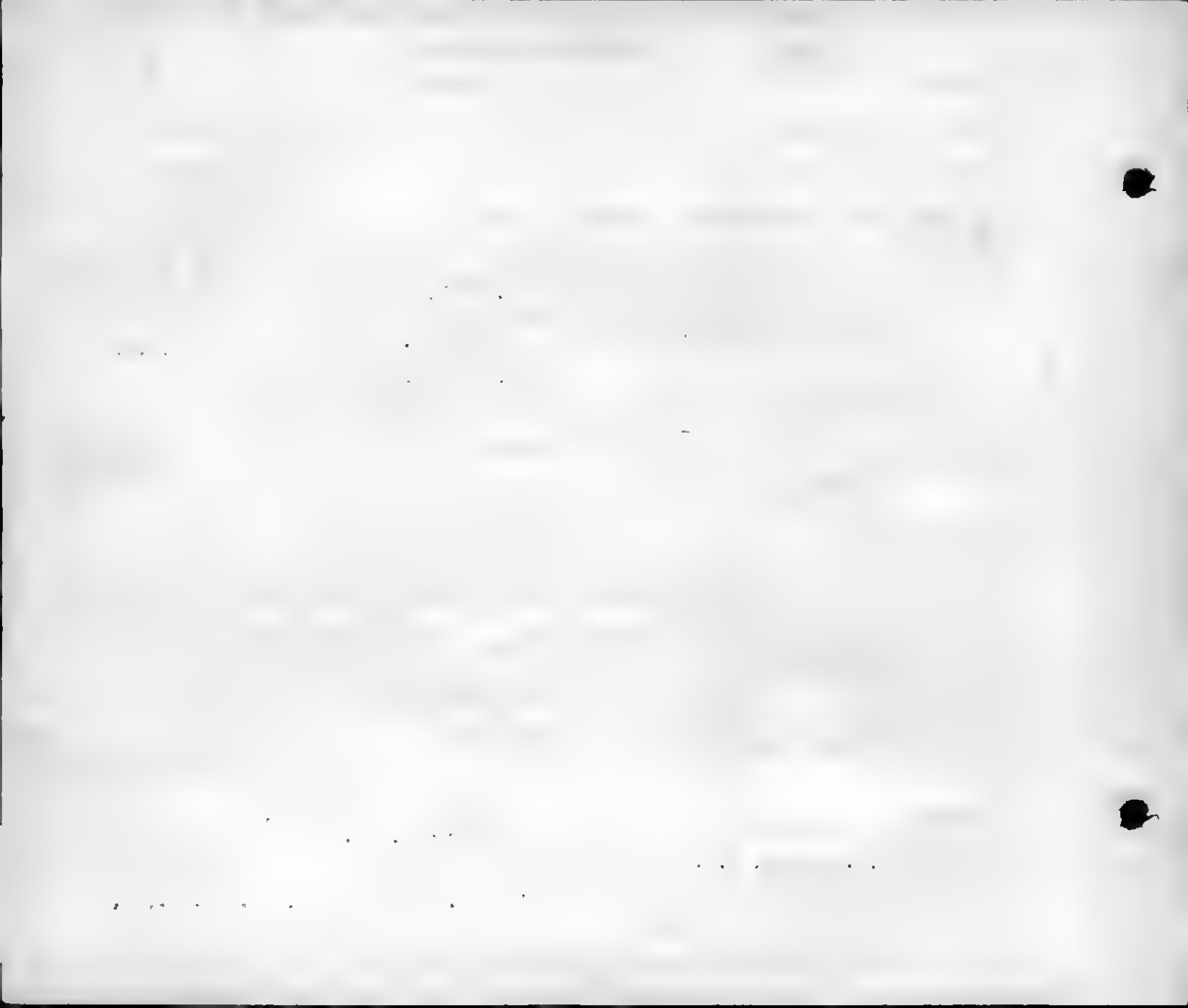
14055

14070

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>				c. LENGTH OF STAY IN 1b <i>50 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Ieland Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>W.</i> Last <i>Miles</i>				4. DATE OF DEATH Month <i>December</i> Day <i>31</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 17th, 1895</i>	9. AGE (In years last birthday) <i>64</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James Walter Miles</i>				14. MOTHER'S MAIDEN NAME <i>Minnie Weiskettel</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>unknown</i>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <i>None</i>		17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] --							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>							
352X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <i>Arteriosclerosis</i>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) <i>Hypertensive Cardiovascular disease</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <i>3-16</i> , 19 <i>59</i> , to <i>12-31</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-30</i> , 19 <i>59</i> , and that death occurred at <i>5:15</i> A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <i>D. R. Purdie</i> M.D.				4408 Queensbury Road, Riverdale, Md.		12/31/59	
PHYSICIAN'S NAME (Type) <i>D.R. Purdie, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/2/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Washington Nat'l Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Pr. Geo. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers &amp; Co. Riverdale Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JAN 4 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Anna</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File 3254 1-4-60 et

## CERTIFICATE OF DEATH

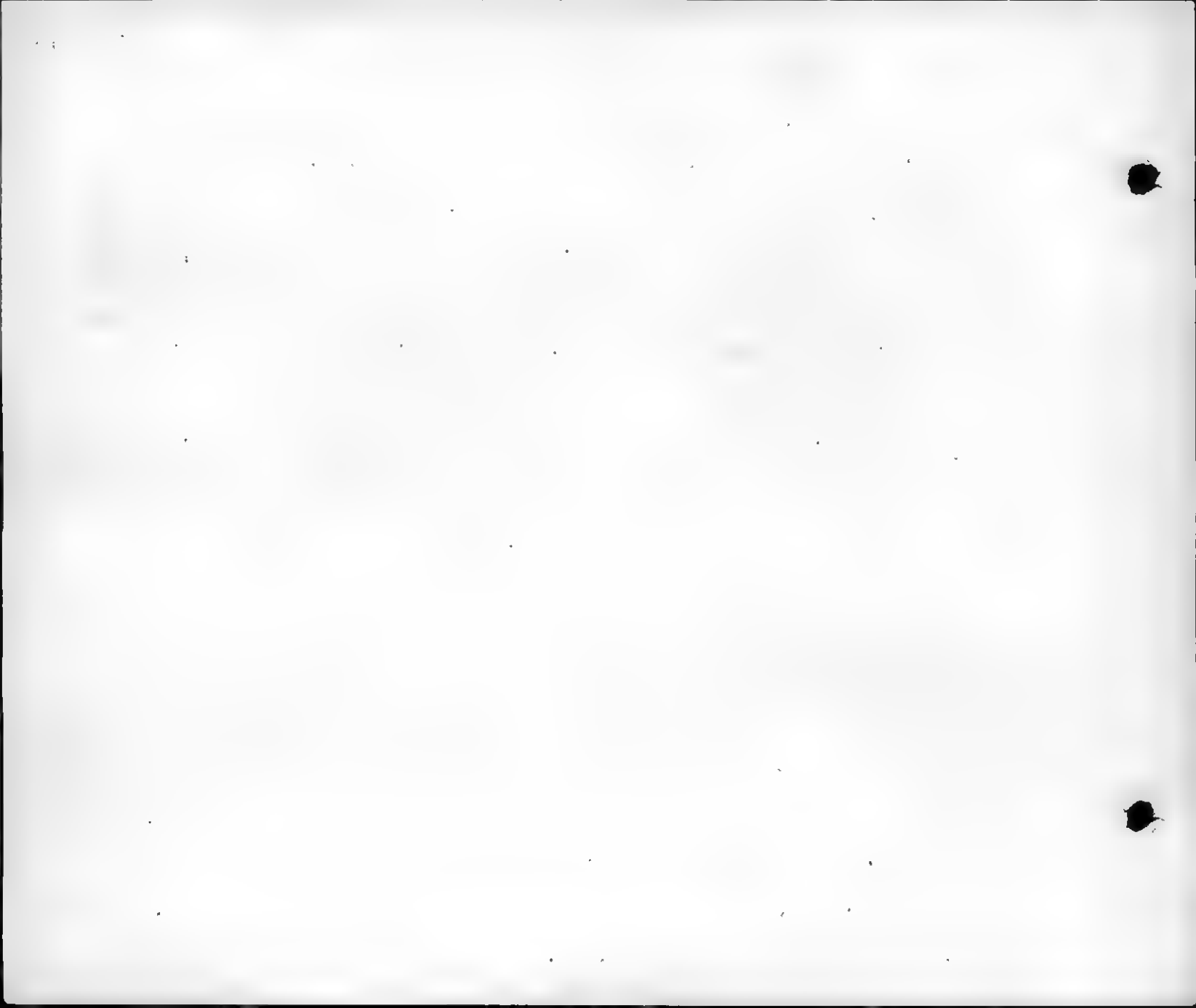
14056

Reg. Dist. No.

14071

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN 1b <b>4 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5304 Taylor Rd</b>				e. STREET ADDRESS <b>5304 Taylor Rd</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>C</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 20, 1892</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>67</b> Days <b>00</b> Hours <b>00</b> Min.	IF UNDER 24 HRS Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington Gas Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Marshall Miller</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Julia M White Hyattsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest (Cerebrovascular)</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>12-18 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-27</b> 19 <b>59</b> , to <b>12-18</b> 19 <b>59</b> , that I last saw the deceased alive on <b>12-18</b> 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4314- GALLATIN ST. HYATTSVILLE, MD.</b> DATE SIGNED <b>DEC 22 1959</b>							
ACTUAL SIGNATURE <b>AARON DEITZ M.D.</b>							
PHYSICIAN'S NAME (Type) <b>AARON DEITZ M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 22, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14072

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>45 Min.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Riverdale</b>		d. STREET ADDRESS <b>5415 Powhatan Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-18-89</b>	
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min <b>70</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Southern Dairies</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Marshall M. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Taylor</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO <b>578 10 2659</b>				INFORMANT <b>Mrs Faith Miller</b> Address <b>Riverdale, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12-7</b> , 19 <b>53</b> , to <b>12-26</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12-26</b> , 19 <b>59</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>R.D. BAUER, M.D.</b>				ADDRESS (Street, city or town, state) <b>2513 Brookledge Rd.</b>				DATE SIGNED <b>12-26-59</b>			
PHYSICIAN'S NAME (Type) <b>R.D. BAUER, M.D.</b>				M.D. <b>ADELPHI, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec 30, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Catharine S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 254 1-4-60 et

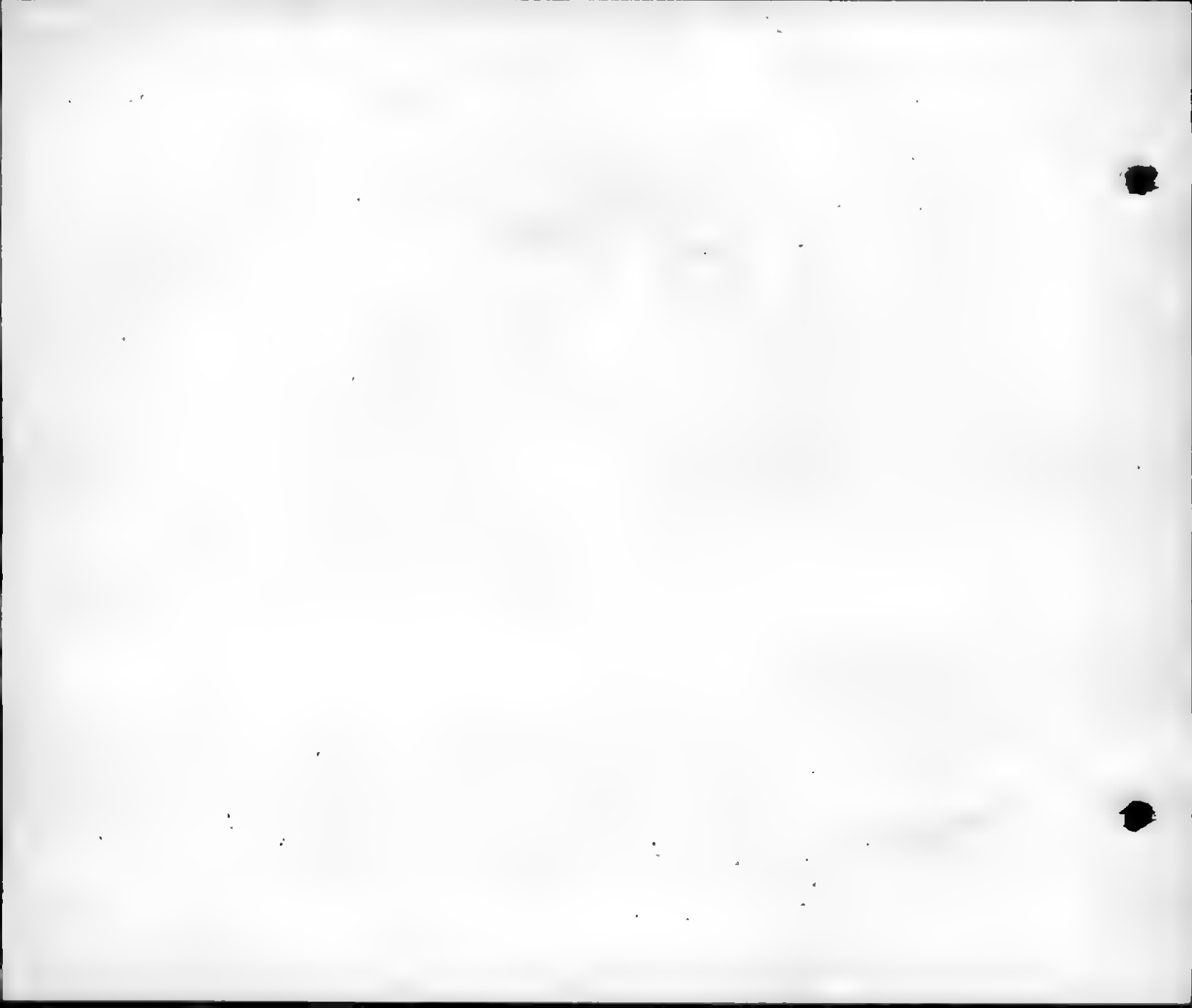
## CERTIFICATE OF DEATH

Reg. Dist. No.

14058

14073

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>Adelphi Rd. &amp; Windon Ave</b> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George William</b> Middle <b>Montgomery</b> Last <b></b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>18</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18 1901</b>
9. AGE (In years last birthday) <b>58</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Anna Robey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>Yes</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Lelia wife as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>452X</b> DUE TO <b>Aspirated in car night 12/18/59</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>intoxication</b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12/17</b> , 19 <b>59</b> , to <b>12/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/18/59</b> , 19 <b></b> , and that death occurred at <b>4:05 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. A. Holbrook</b>		ADDRESS (Street, city or town, state) <b>4500 College Ave., Prince George, Md.</b> DATE SIGNED <b>12/18/59</b>	
COUNTERSIGNED: <b>John S. Milgram</b> PHYSICIAN'S NAME (Type) <b>William A. Holbrook</b>		M.D. <b>Deputy Medical Examiner</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>George Wash. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>DEAL FUNERAL HOME</b>		ADDRESS <b>4812 Ga Ave NW</b>	
24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. E. Jones</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14059

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				f. STREET ADDRESS <b>Railroad Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Winfield Morgan, Sr.</b>				4. DATE OF DEATH Month Day Year <b>December 14, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-28-1901</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Purchasing Advisor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Library of Congress</b>		11. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas W. Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Laura E. Otto</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>George W. Morgan; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 14, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

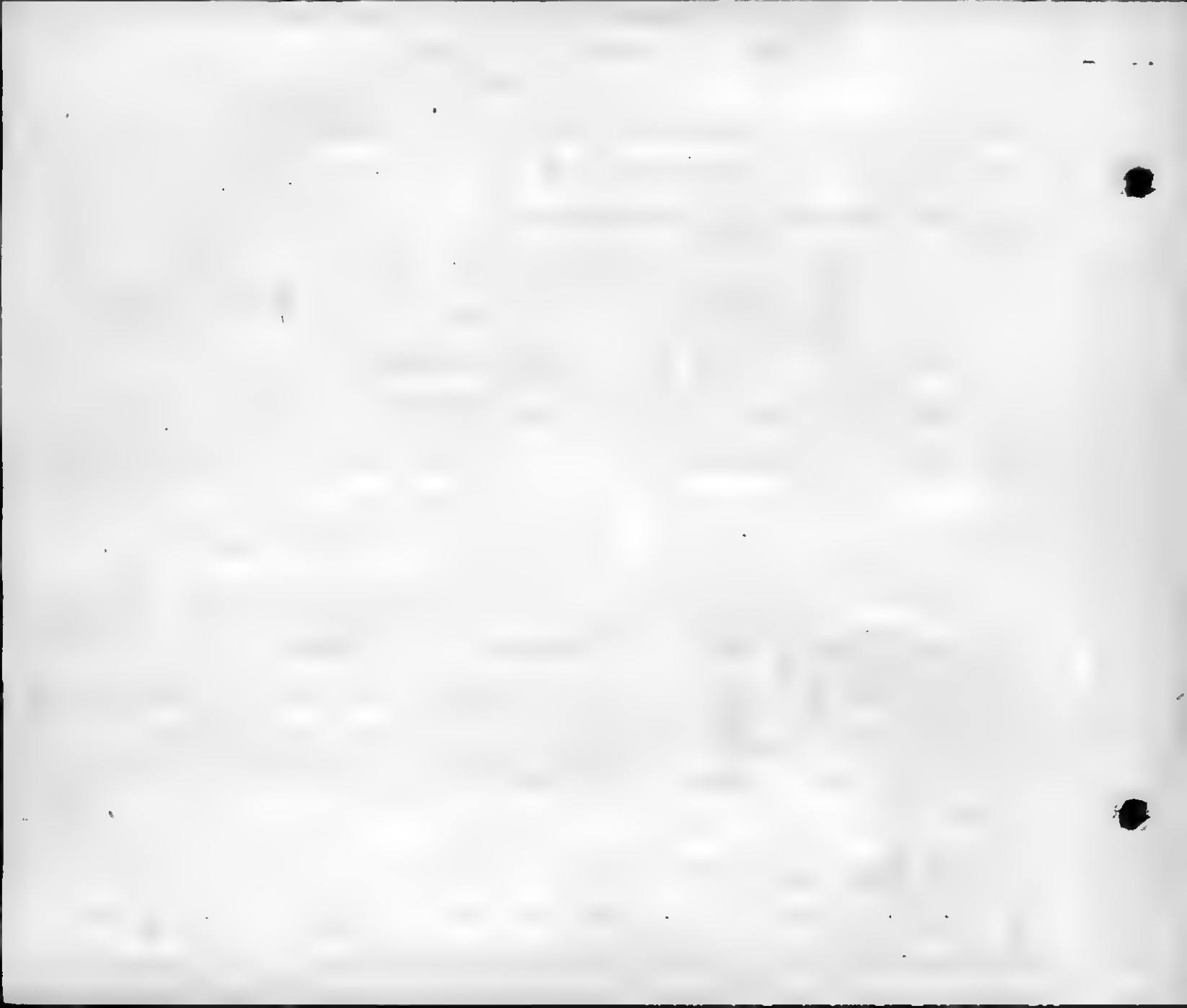
14075

## CERTIFICATE OF DEATH

Reg. Dist. No.

14060

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BETHESDA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>adm. June 6-59</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>				d. STREET ADDRESS <u>4890 BATTERY AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BRIDGET</u> Middle <u>GARWAY</u> Last <u>MURPHY</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-1875</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u>	IF UNDER 24 MRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard - GOLWAY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET GOLWAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>126-07-3937</u>		17. INFORMANT <u>Hosp. Records LAUREL SANITARIUM</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I.—DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FIBRILLATION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile dementia (arteriosclerotic)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6-</u> 19 <u>59</u> to <u>Dec-3-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Dec-3-</u> 19 <u>59</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Erika P. Kraemer</u>		M.D. <u>LAUREL SANITARIUM</u>		ADDRESS (Street, city or town, state) <u>LAUREL MARYLAND</u>		DATE SIGNED <u>12-3-59</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. Bur.</u>		22b. DATE THEREOF <u>12-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cayoga County, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John E. Kenna</u>	



14076

CERTIFICATE OF DEATH

Reg. Dist. No.

14061

1. PLACE OF DEATH a. COUNTY <b>Prince georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>M</b> Last <b>Nau Sr.</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 June 1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Gun Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Chicago Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Henry Nau</b>		14. MOTHER'S MAIDEN NAME <b>Welhelimina Krause</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Ellen Esther Nau</b>		Address <b>Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO <b>Saddle embolus aceto</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarction</b> DUE TO <b>hypertension cardiac vascular</b> (c) <b>hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>48 hrs</b> <b>5 days</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemorrhage 12-18-59. Brain fracture</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-28</b> , 19 <b>55</b> to <b>12-23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-23-59</b> , 19 <b>59</b> , and that death occurred at <b>3:00AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John P. Clum</b>		ADDRESS (Street, city or town, state) <b>Hyattsville Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Clum M.D.</b>		DATE SIGNED <b>12-23-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hyattsville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
ADDRESS <b>Hyattsville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

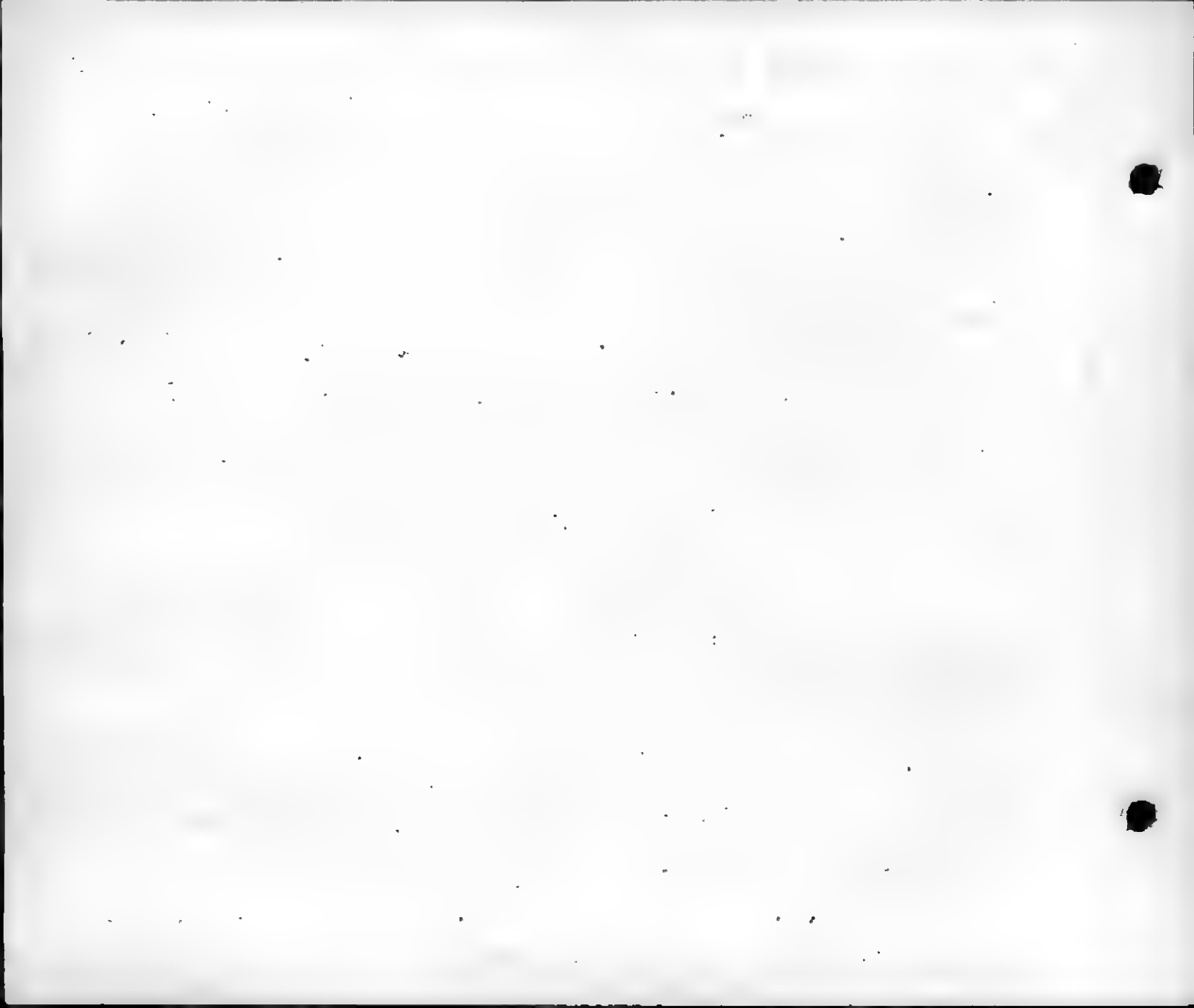
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14062

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmount Hgts, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Broom's Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura</u> First <u>Nichols</u> Last		4. DATE OF DEATH <u>Dec. 28</u> 19 <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>76</u> yrs.
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Colorado</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Isiah Mitchell</u>	
14. MOTHER'S MAIDEN NAME <u>Lucinda Mitchell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO <u>NO</u>		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral-HEMORRHAGE</u> DUE TO <u>with Rt. Hemiplegia</u> (b) <u>ARTERIOSCLEROSIS</u> DUE TO <u>?</u> (c) <u>?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture RT- HIP</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>12-24</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>INJURED IN FALL</u>	
21. TIME OF INJURY Month, Day, Year <u>Sept 22-1959</u>		22. PLACE OF INJURY (Home form, factory, street, office bldg., etc.) <u>?</u>	
23. TIME OF INJURY Hour a. m. p. m. <u>11:40 PM</u>		24. PLACE OF INJURY (City or town) (County) (State) <u>?</u>	
25. I certify that I attended the deceased from <u>10-31</u> , 19 <u>59</u> , to <u>12-28</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12-24</u> , 19 <u>59</u> , and that death occurred on <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. G. Beldon</u>		DATE SIGNED <u>DEC 28 1959</u>	
PHYSICIAN'S NAME (Type) <u>H. G. Beldon MD</u>		ADDRESS (Street, city or town, state) <u>11423 - HUNT PL NE DC</u>	
26. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	27. DATE THEREOF <u>12.29.59</u>	28. NAME OF CEMETERY <u>Nat'l. Harmony Mem. Park</u>	29. LOCATION (City, town, or county) (State) <u>Prince George's, Maryland</u>
30. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>		31. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	
ADDRESS <u>1820 9th St., N.W.</u>		DATE <u>DEC 28 '59</u>	
Washington, D.C.			



## CERTIFICATE OF DEATH

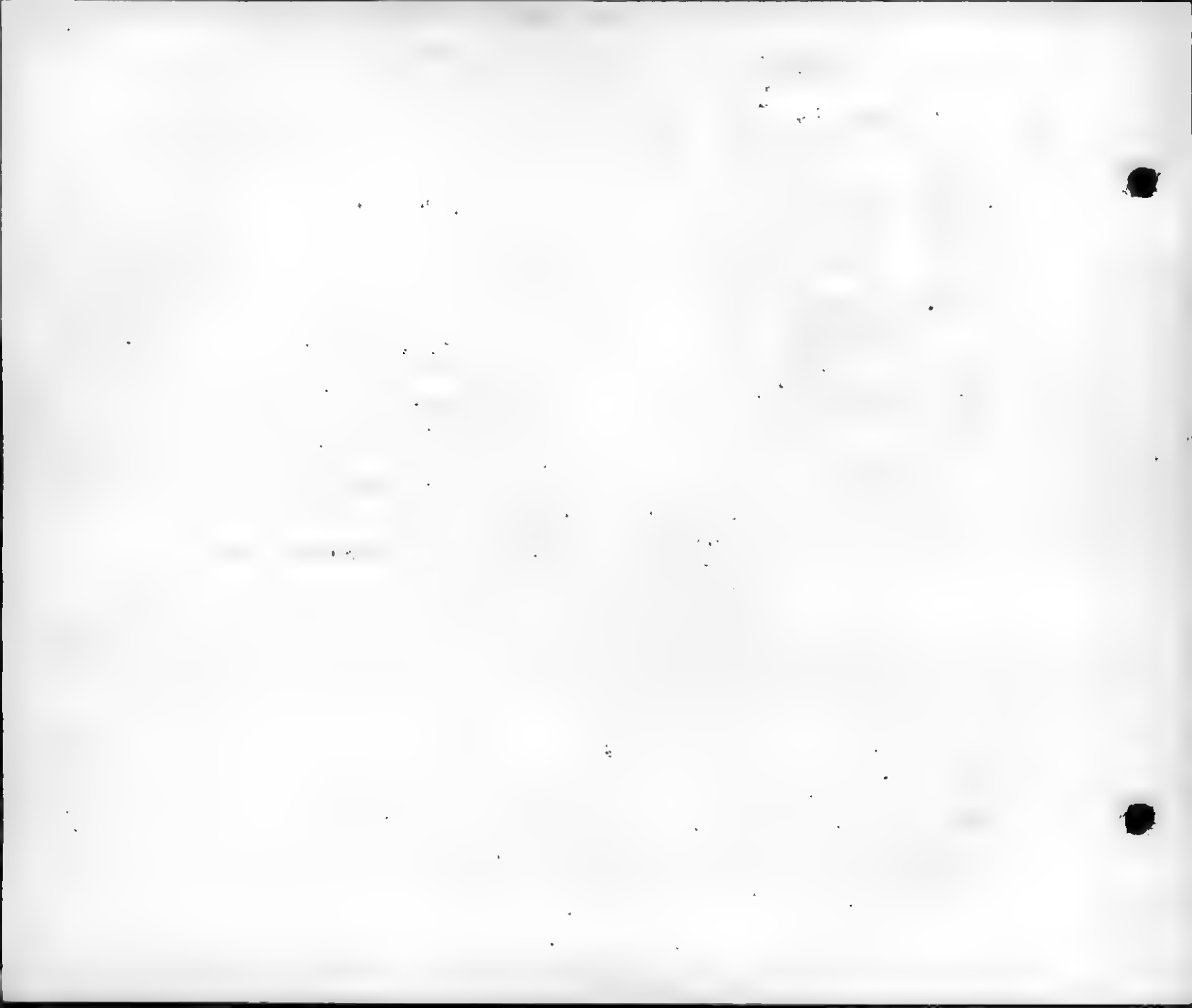
Reg. Dist. No.

14077

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>42 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		d. STREET ADDRESS <b>3505 Upshur St.</b>	
3. NAME OF DECEASED (Type or print) <b>Minnie</b>		4. DATE OF DEATH Month <b>12-</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-78</b>
9. AGE (In years last birthday) <b>81</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Casper Sauter</b>		14. MOTHER'S MAIDEN NAME <b>Annie Sauter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Informant</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism with Infarction</b> <b>450.1</b> DUE TO <b>Thrombosis of rt. Iliac Vein</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Amputation of Legs</b> DUE TO <b>Gangrene of legs secondary to Arteriosclerosis</b> (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>53</b> , to <b>Dec 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 7</b> , 19 <b>59</b> , and that death occurred at <b>7:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leon L. Gallin</b>		ADDRESS (Street, city or town, state) <b>7306 Colesville Rd</b>	
PHYSICIAN'S NAME (Type) <b>LEON. L. GALLIN M.D.</b>		DATE SIGNED <b>12/9/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Albans</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Unittley Haddon</b>		24a. REC'D BY REGISTRAR <b>DEC 18 '59</b>	
ADDRESS <b>3831-96 Ave NW</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





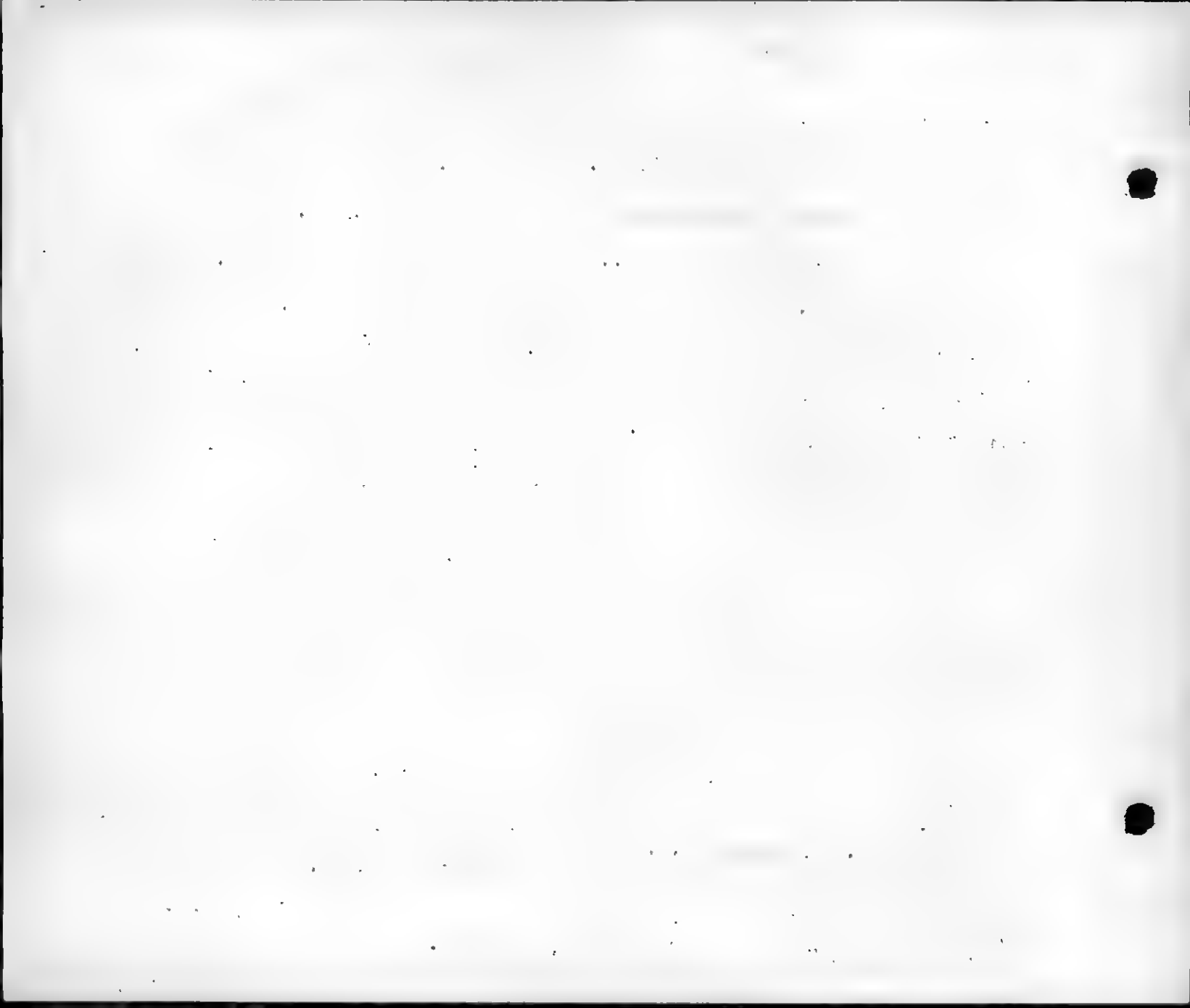
14078

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>21 Da.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3300 Chauncy Pl.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>T.</b> Last <b>O'Connell</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>19 59</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-23-1897</b>		9. AGE (In years last birthday) <b>62</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>yard-man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>Fredrick M. O'Connell</b>				14. MOTHER'S MAIDEN NAME <b>Agnes W. O'Connell</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW1</b>				16. SOCIAL SECURITY NO. <b>578-01-7558</b>				INFORMANT <b>Frelyn B. O'Connell</b> Address <b>Wife</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of the lung</b> DUE TO (c) <b>Bone metastases.</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1</b> , 1959, to <b>Dec. 24</b> , 1959, that I last saw the deceased alive on <b>12-24</b> , 1959, and that death occurred at <b>9:17 PM</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>George Hageage</b>				ADDRESS (Street, city or town, state) <b>3717-38th Ave</b>				DATE <b>12-25-59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Geo Hageage M.D.</b>				Cottage City, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-28-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>		22d. LOCATION (City, town, or county) (State) <b>Washinton, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A Mattingly</b>				ADDRESS <b>Wash. D.C.</b>		REC'D BY REGISTRAR <b>131-11-48</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 14065

14016

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>WASH. DC</u> b. COUNTY <u>DISTRICT OF COLUMBIA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>1 YR 3 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 LASALLE</u>				e. STREET ADDRESS <u>3660 CONN. AVE. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>O'CONNOR</u> Last <u>O'CONNOR</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 16, 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIRE CHIEF</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRAINSVILLE VA</u>			
11. BIRTHPLACE (State or foreign country) <u>UNITED STATES</u>				12. CITIZEN OF WHAT COUNTRY <u>UNITED STATES</u>			
13. FATHER'S NAME <u>THOMAS O'CONNOR</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN KENNEDY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO <u>no</u>			
INFORMANT <u>SISTER AGNES PATRICIA-CARROLL MANOR</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>intractable heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>myocardial infarct</u> DUE TO (c) <u>coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 da</u> <u>10 da</u> <u>10+ da</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>59</u> , to <u>12/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/11</u> , 19 <u>59</u> , and that death occurred at <u>10:20 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D.				ADDRESS (Street, city or town, state) <u>4323 Harvard St. S.E. S.W.</u>			
DATE SIGNED <u>12/14/59</u>							
PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Hines</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14115

## CERTIFICATE OF DEATH

Reg. Dist. No.

14066

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park Hgts				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park Hgts			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 4510 Temple Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Fred Middle V Last Ousley		4. DATE OF DEATH Month December Day 17 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1909		9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Naval Ordnance		11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Esco L. Ousley				14. MOTHER'S MAIDEN NAME Maria Warwick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Edith M. Ousley		Address 4510 Temple Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CROMARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 MONTHS INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1958 to DECEASED 17/1959, that I last saw the deceased alive on 12/17 1959, and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE WRITTEN X Bruno Kolega M.D. 4233 ST. BARNABAS RD - SE WASHINGTON D.C. PHYSICIAN'S NAME (Type) BRUNO KOLEGA - M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59		22c. NAME OF CEMETERY OR CREMATORY Brookalter Cem.		22d. LOCATION (City, town, or county) (State) Inskip Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS West. DE		24a. REC'D BY REGISTRAR DATE DEC 23 '59	
				24b. REGISTRAR'S SIGNATURE C. H. H. H. H.			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 14116 14116 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

14067

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 23 DC</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4404 Porter Ave S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janie Ann Payne</u>		4. DATE OF DEATH <u>12-11-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 21-1881</u>
9 AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sylvester Gant</u>		14. MOTHER'S MAIDEN NAME <u>Janie - - unknown</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Janie Teresa Payne</u>		Address <u>4404 Porter Ave Washington 23 DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Totally blind and General Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Natural Cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> 19 <u>58</u> to <u>Dec 11</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 10</u> 19 <u>59</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.		ADDRESS (Street, city or town, state) <u>5440 Limerick Hill Rd SE Washington 28 DC</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-15-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Rd Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S Washington</u>		ADDRESS <u>467 N st NW</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlando S. Howard</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14007

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14068

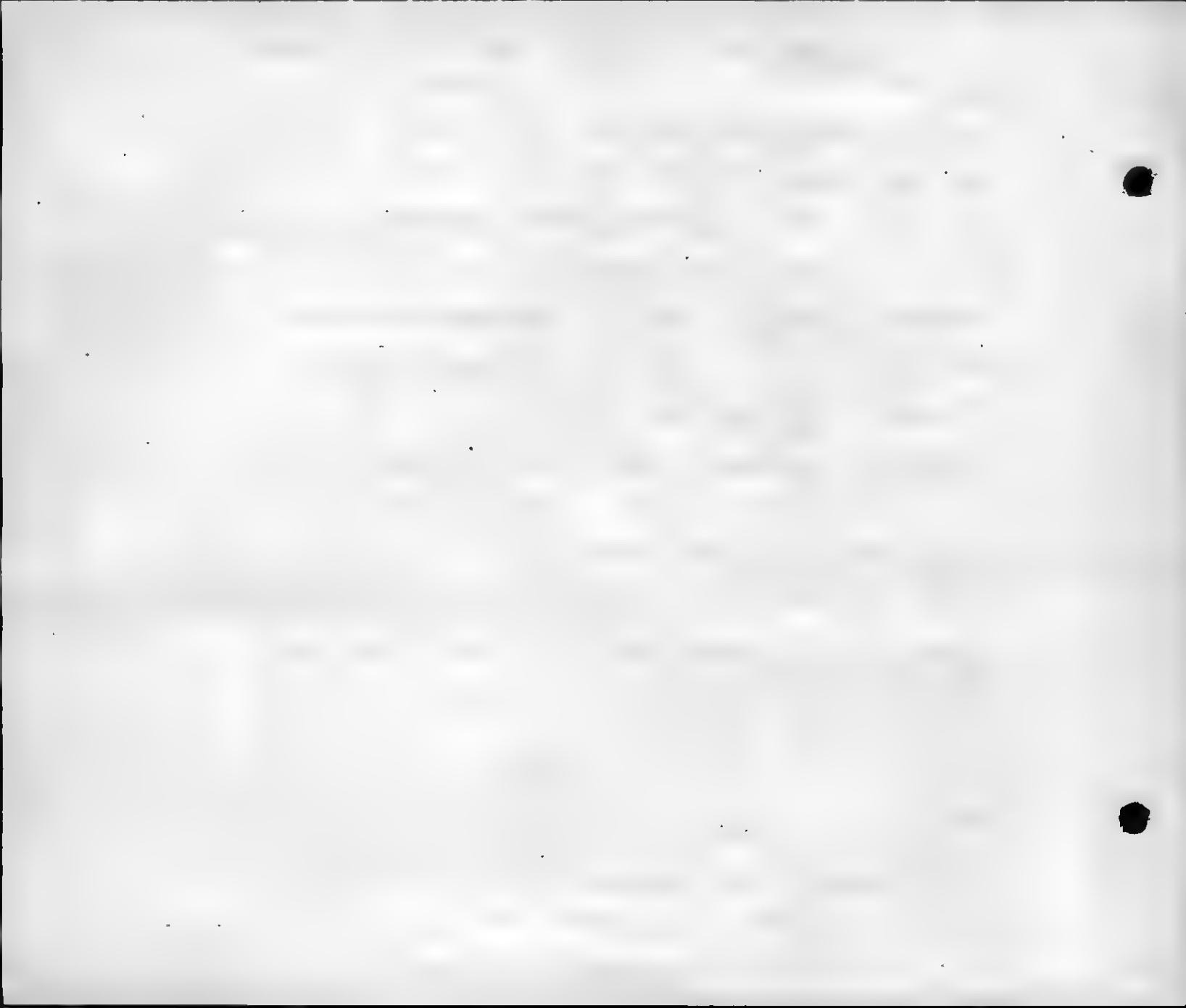
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Bowie</u> <u>George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hi Sea</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>1 1/2 m.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7642-Baltimore Boulevard</u>				e. STREET ADDRESS <u>9042-Baltimore Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lovert</u> Middle <u>Lewia</u> Last <u>Payne</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-5-10</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Winton Payne</u>				14. MOTHER'S MAIDEN NAME <u>Mittie Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>5-77-14-3332</u>		17. INFORMANT <u>Constancia Pectori</u> Address <u>Riverdale Rd</u> <u>Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>  </u> DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-24-59</u>	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certifying officer, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

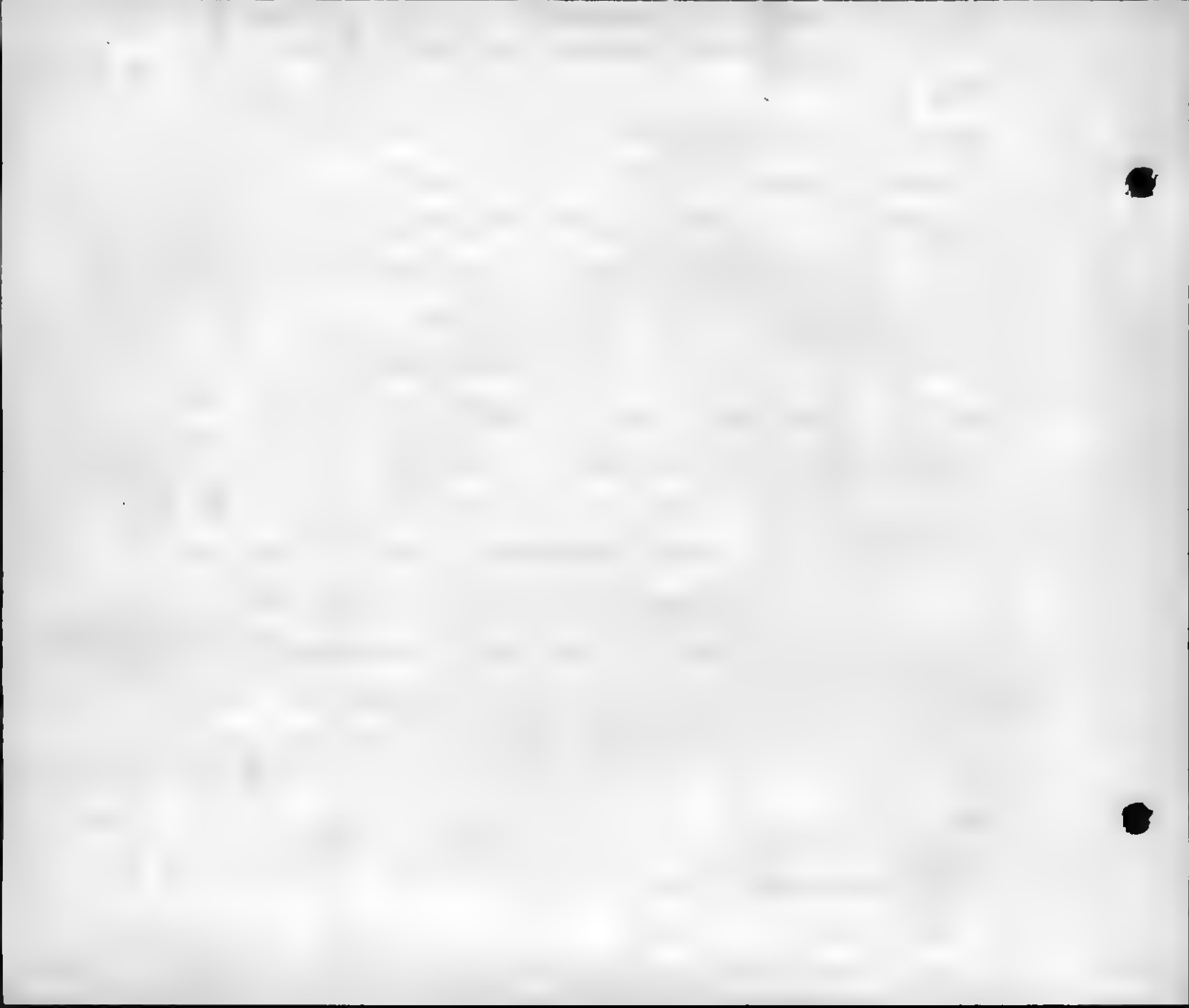
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14063

14117

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silverside</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silverside</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8560 River View Road</u>				e. STREET ADDRESS <u>8560 River View Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>Linn</u> Last <u>Peters</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27, 1910</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchandising</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Philip Gates</u>				14. MOTHER'S MAIDEN NAME <u>Emma Brockner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5796-20-1400</u>		17. INFORMANT Address <u>8550 River View Rd</u> <u>Elizabeth Hutcherson Silverside</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-6-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Broad Creek Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>				ADDRESS <u>1661 9th Hope Rd S E</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



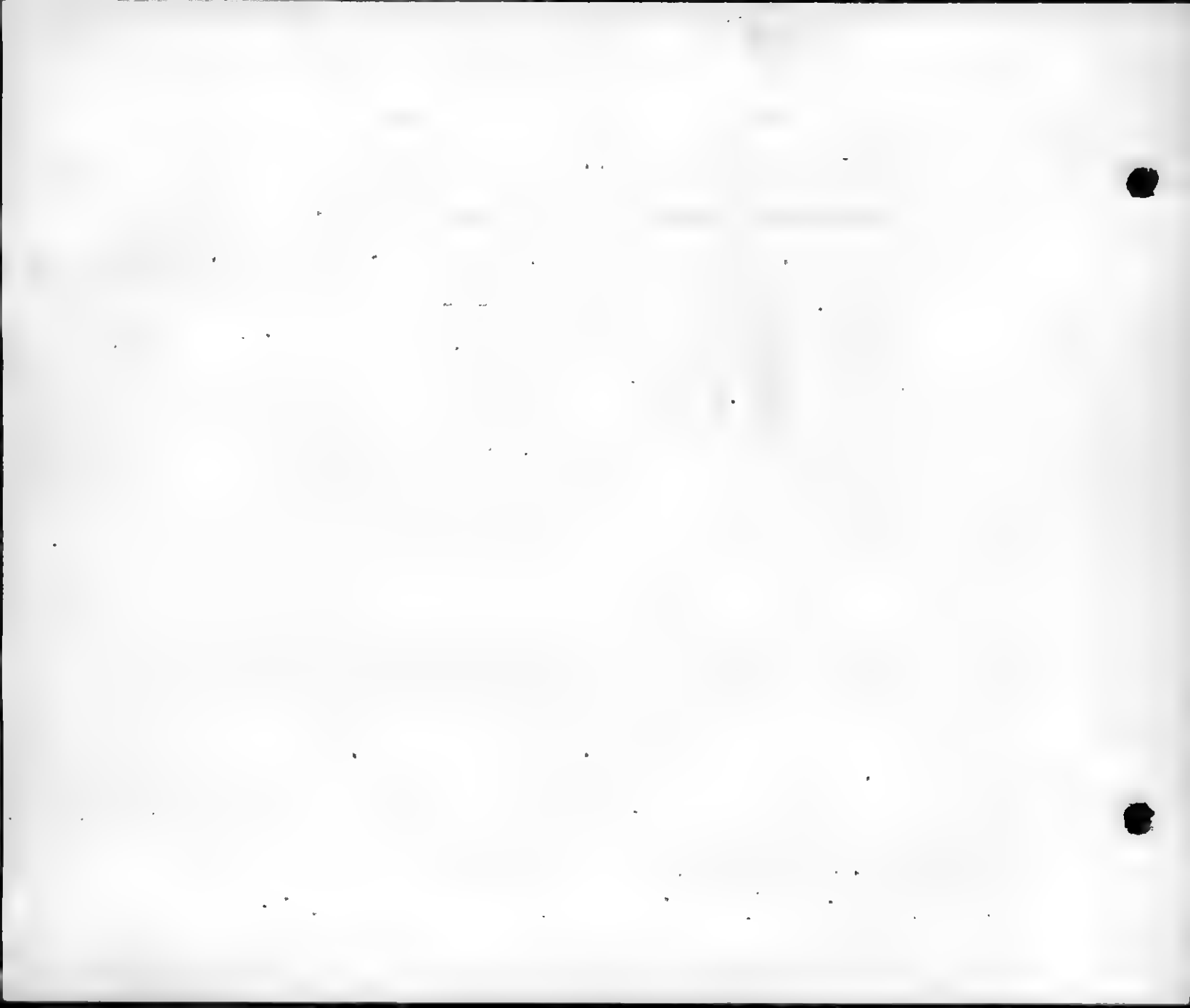
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14079**  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

14070

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>6 Hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Flora B.</b> Middle <b>Phillips</b> Last <b>Phillips</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10- 2- 81</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>GREEN COUNTY, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LINDSAY DULANEY</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN HEADLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		INFORMANT <b>FRANCIS L PHILLIPS</b>		Address <b>TI</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACEREBRAL Hemorrhage</b> DUE TO (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c) <b>2 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>71</b>	(County) (State)			
21. I certify that I attended the deceased from <b>Dec. 21</b> , 19 <b>59</b> to <b>Dec. 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 21</b> , 19 <b>59</b> and that death occurred at <b>8:30 M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <i>Norman Donat Comeau</i>		M.D.		ADDRESS (Street, city or town, state) <b>3503 Perry St Mt Rainier Md</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau</b>		DATE SIGNED <b>12/21/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<b>SHIP RR.</b>	<b>12-24-59</b>	<b>Cedar Grove Cemetery</b>		<b>Mt Morris Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. M. Warrick</i>		ADDRESS <i>2121 Chambers co 1406 Chapin St. N.W.</i>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kiana</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14118

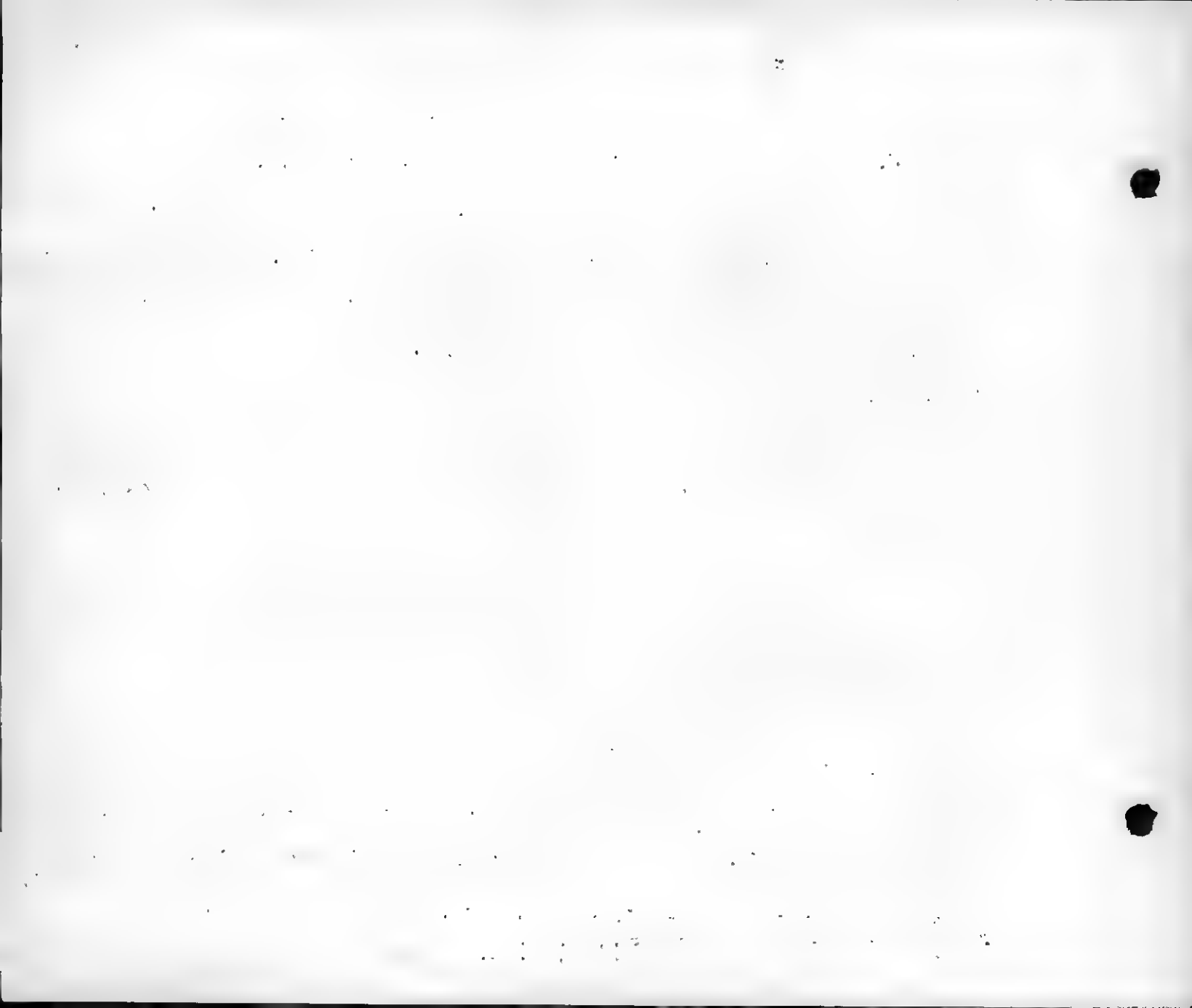
CERTIFICATE OF DEATH

Reg. Dist. No.

14071

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>(DISTRICT OF COLUMBIA)</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>LOT 47 TRAILER COURT ANDREWS</b>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>-----</b> Last <b>PIERCE</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 NOVEMBER 1959</b>
9. AGE (In years last birthday) yrs. <b>11</b>		IF UNDER 1 YEAR: Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>ROBERT LAMAR PIERCE</b>		14. MOTHER'S MAIDEN NAME <b>IRENE ELIZABETH MEYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NA</b>		16. SOCIAL SECURITY NO <b>NA</b>	
17. INFORMANT <b>FATHER</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>763.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>27 NOVEMBER</b> , 19 <b>59</b> , to <b>19</b> , that I last saw the deceased alive on <b>7 DECEMBER</b> , 19 <b>59</b> , and that death occurred at <b>1230P</b> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Vincent P Ringrose, Jr.</b>		ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b> DATE SIGNED <b>7 DEC 59</b>	
PHYSICIAN'S NAME (Type) <b>VINCENT P RINGROSE CAPT USAF MC USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH 25</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rinaldi Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DEC 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

2050362XV1





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14072

14080

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chantilly		c. LENGTH OF STAY IN 1b Dead at home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		4:15-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 14097orfal Road NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest R Post				4. DATE OF DEATH Dec 2 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17, 1884		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired		10b. KIND OF BUSINESS OR INDUSTRY DC Water Dept		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hyacinth Strauff Elect City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I Boyd				DATE SIGNED Dec 2, 1959			
EXAMINER'S NAME (Type) James I Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/5/59		22b. DATE THEREOF 12/5/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Chas Chase Funeral Home				ADDRESS 5100 Waco Ave		24a. REC'D BY REGISTRAR DATE DEC 7 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Hand			



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14119

CERTIFICATE OF DEATH

Reg. Dist. No.

14073

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hght.		c. LENGTH OF STAY IN 1b 4 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5041--Dunlap St., S.E.		d. STREET ADDRESS 5041--Dunlap St., S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS F. PRATHER		4. DATE OF DEATH Month Day Year Dec. 17th 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1923
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Creditor Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Gulf Discount Corp.	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Prather		14. MOTHER'S MAIDEN NAME Jane Cowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. INFORMANT Jane B. Prather-Wife	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Two previous myocardial infarctions		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 to Nov. 1959, that I last saw the deceased alive on Nov. 24, 1959, and that death occurred at 445 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward J. Pacious M.D.		DATE SIGNED 1746 K St., N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) Dr. Ed J. Pacious		1746-K St., N.W. Wash. DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		ADDRESS 1661--Good Hope Rd., SE Wash. 20, DC	
24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14120

## CERTIFICATE OF DEATH

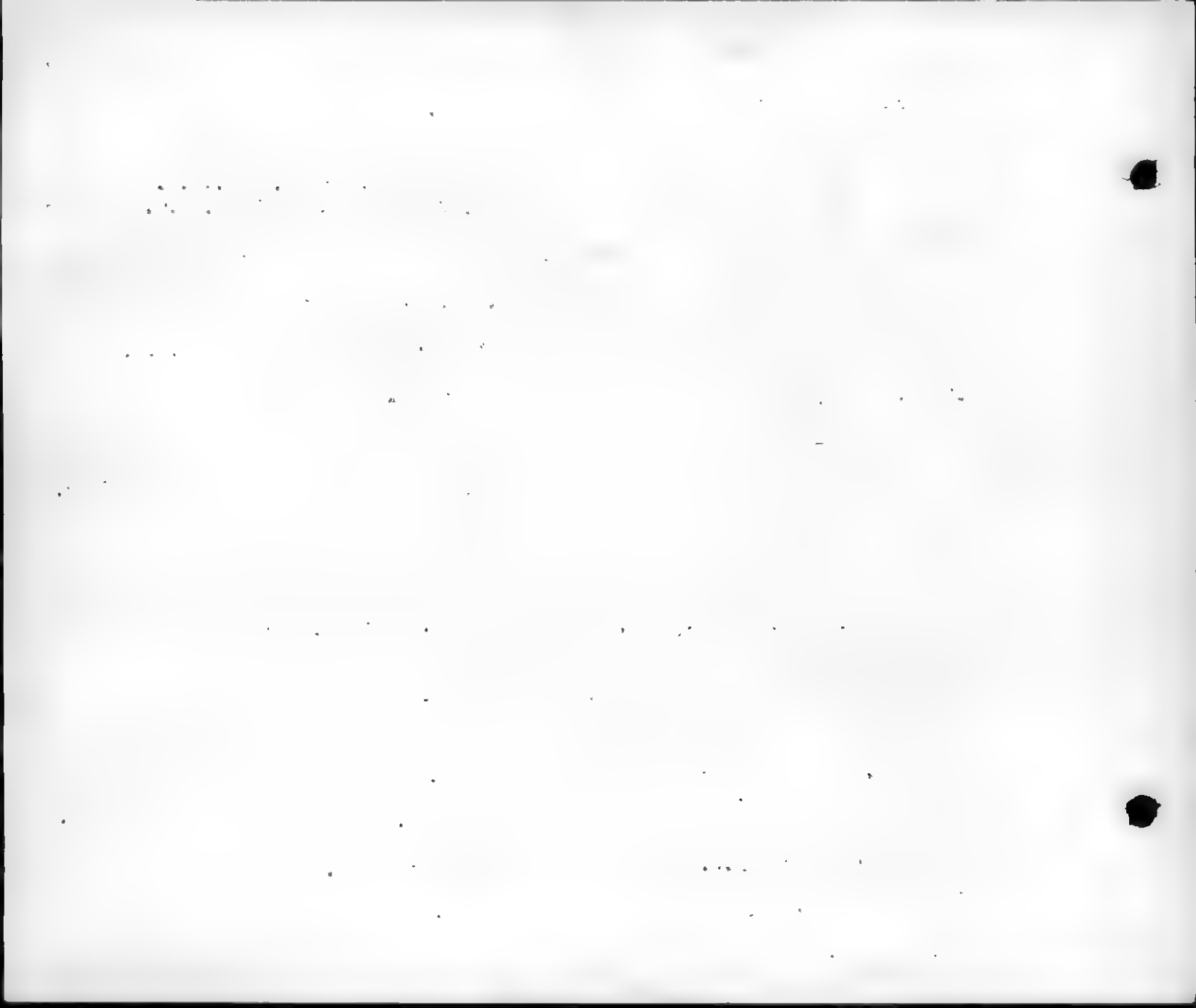
Reg. Dist. No.

14074

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Dist. of Columbia</b> b. COUNTY <b>✓</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Glenn Dale)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN lb <b>57 Days</b>		d. STREET ADDRESS <b>1766 Penna. Ave., N.W.</b> <b>Glenn Dale, Maryland Wash., D.C.</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Prettyman</b>		4. DATE OF DEATH Month Day Year <b>December 25 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1890</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John A. Prettyman</b>	
14. MOTHER'S MAIDEN NAME <b>Ella Jones</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT Address <b>Person</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far Advanced</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bullous Emphysema; Cor pulmonale with Congestive failure, compensated</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 mo.</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>10/30</b> , 19 <b>59</b> , to <b>12/25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/25</b> , 19 <b>59</b> , and that death occurred at <b>12:15 P.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Moe Weiss</b> M.D. <b>Glenn Dale Hospital</b>		DATE SIGNED <b>12/25/59</b>	
PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Williams Sons</b> ADDRESS <b>1756 Penna. Ave. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14075

14081

Item 7 Film 4253 12-16-59 et

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>12 hrsn</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Princes Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>Cheverly Cedar Haven</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print) <b>Sarah</b> First <b>C</b> Middle <b>Reeves</b> Last		4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Negro- Fm.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-20-80</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	11. UNDER 24 HRS. Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary M. Jones Aquassee</b> Address <b>vine</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pulmonary Embolism</b> <b>142.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of rt. Femoral vein</b> (c) <b>Carcin oma of Paroid Gland</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b> EXAMINER'S NAME (Type) <b>Dr. John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-9-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>12/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>	22d. LOCATION (City, town, or county) (State) <b>Aquassee, Prince Georges, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Nelson</b> ADDRESS <b>Aquassee</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 10 59</b>	24b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

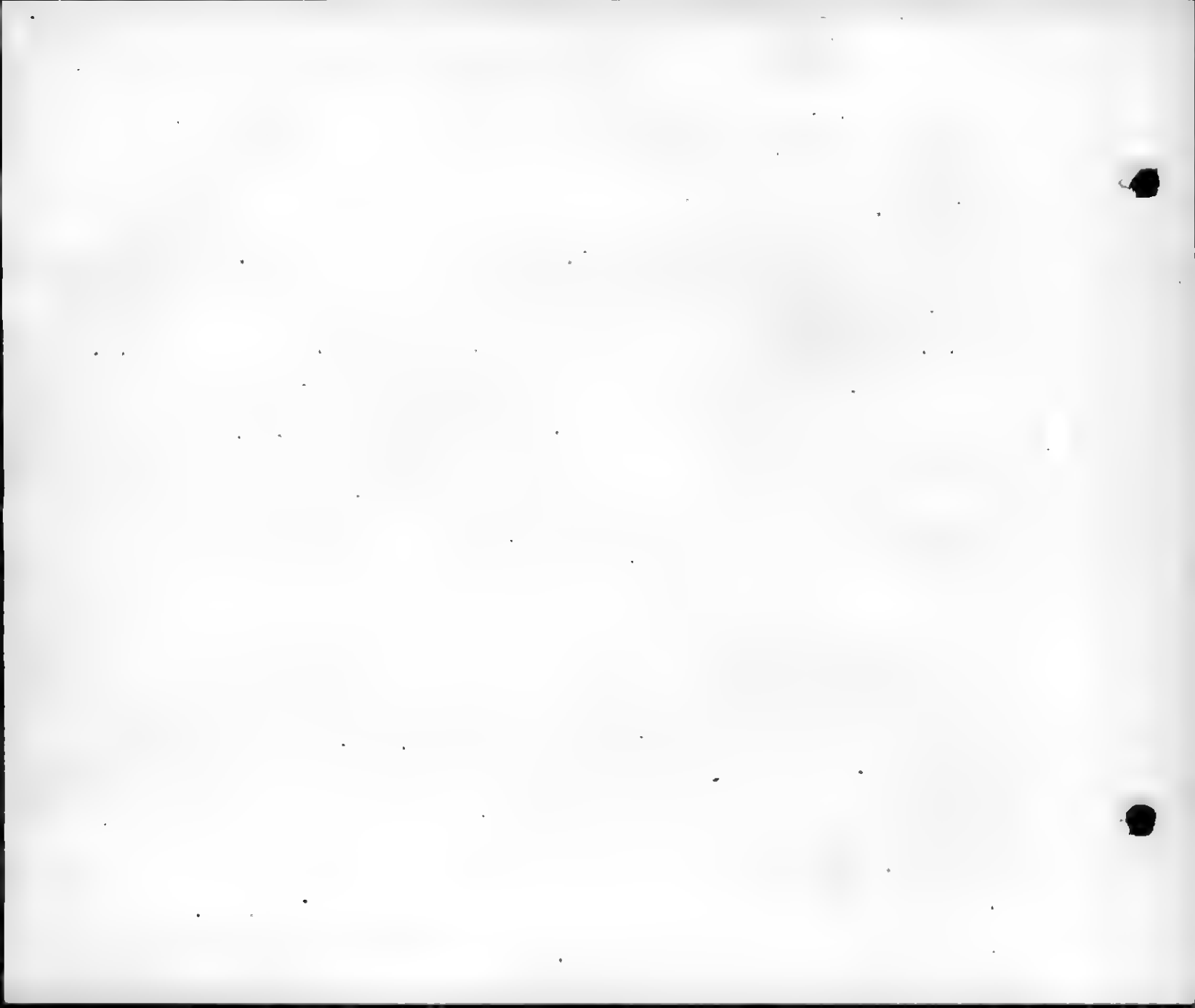




CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince /Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b> d. STREET ADDRESS <b>1204-54th Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>B. Rhodes</b> Last <b>B. Rhodes</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3 - 13 - 13</b>	
9. AGE (In years last birthday) <b>46</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Gustav Ey.</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Michael</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>		16. SOCIAL SECURITY NO. <b>577-01-2689</b>		INFORMANT Address <b>John T Rhodoc -same as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukytopemia - Chronic</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ch. Myelogenous Leukemia</b> DUE TO (c) <b>2 yr 5.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 1</b> , 19 <b>57</b> , to <b>12-8</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12-8</b> , 19 <b>59</b> , and that death occurred at <b>12:18</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>George Hagege</b> M.D. <b>3717-38th St</b> <b>12-8-59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Dr. George Hagege</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>It Myer. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D. C.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

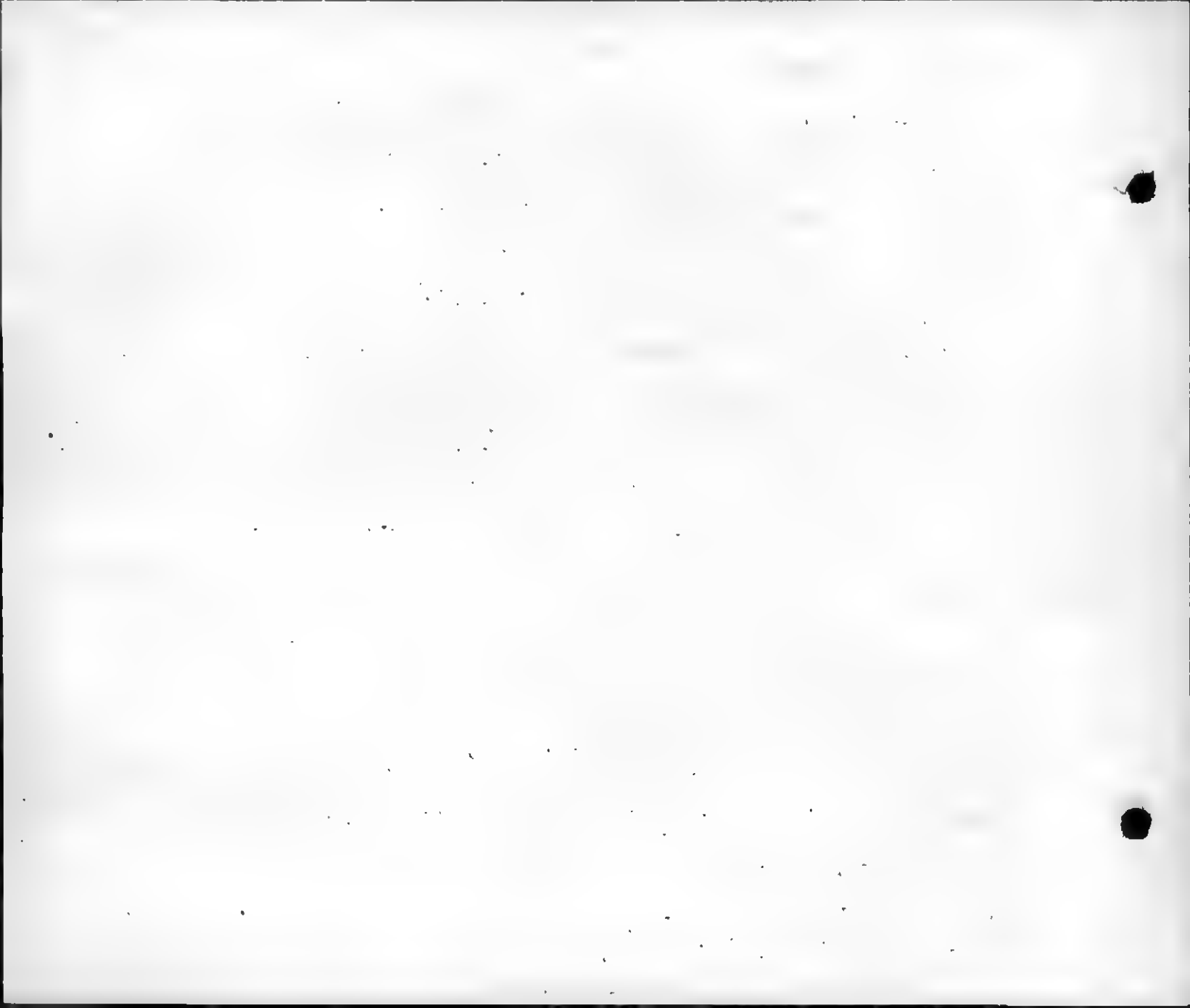
14077

14083

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 yrs -</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE</b> First Middle Last <b>C. RINGGOLD</b>		4. DATE OF DEATH Month <b>12</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26 - 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Island Queen Anne's Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James B Ringgold</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Nelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Elizabeth R Storey</b> Address <b>6311 Annapolis Rd Landover Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHRONIC CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>Coronary Sclerosis from atherosclerosis</b> DUE TO (c) <b>lying cause lost.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 11-15-1959</b> , to <b>12-27-1959</b> that I last saw the deceased alive on <b>11-15-1959</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Albert Roth</b> M.D.		ADDRESS (Street, city or town, state) <b>RIVERDALE, Md</b> DATE SIGNED <b>12-27-59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Albert Roth</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Stonemille</b>	22d. LOCATION (City, town, or county) (State) <b>Stonemille Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Boring of Barton Bros., Centerville, Md</b>		24a. REC'D BY REGISTRAR <b>JAN 5 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58

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14078

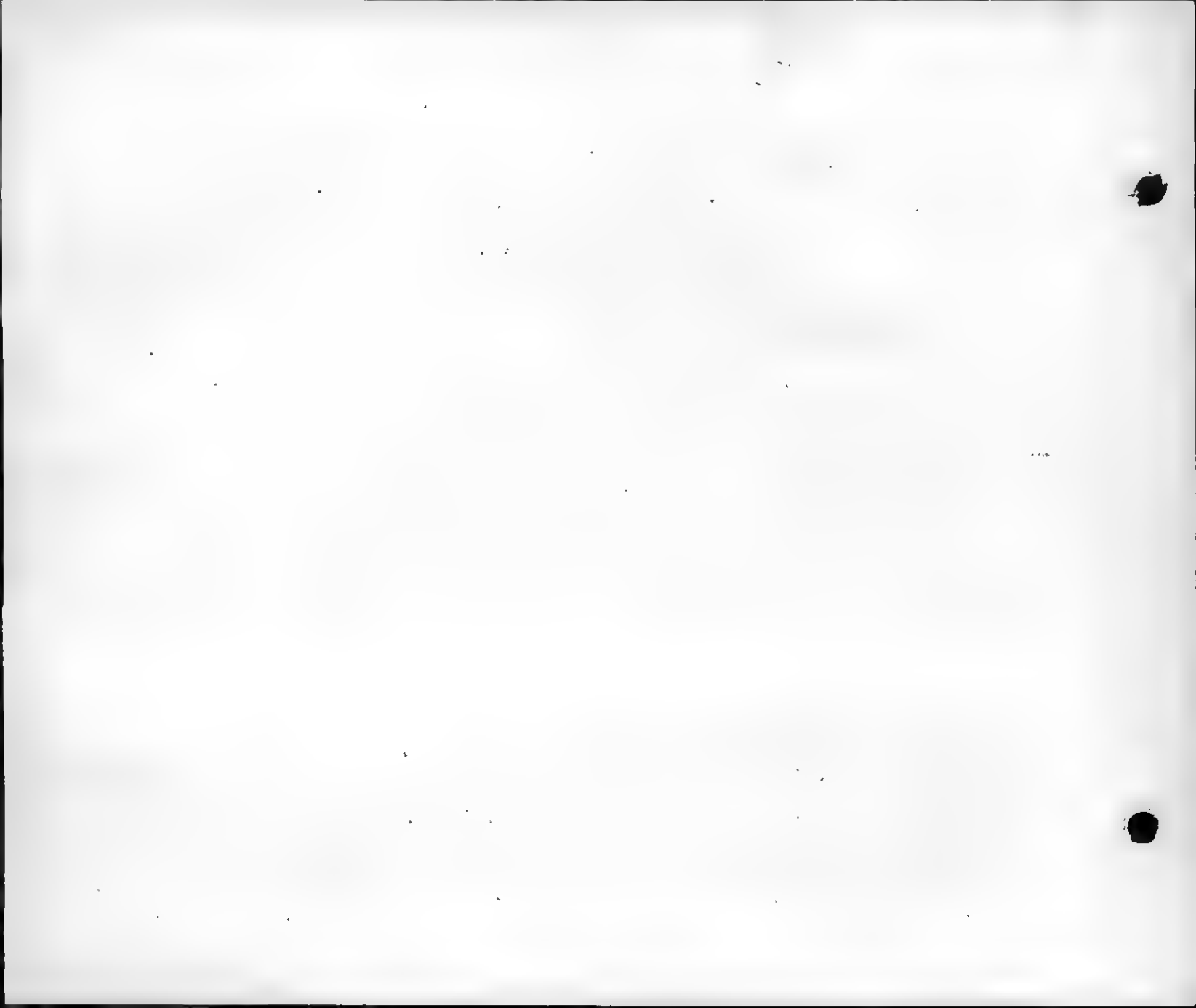
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON (Rural)</u>		c. LENGTH OF STAY IN 1b <u>23 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SO. MARYLAND HOSPITAL CENTER</u>		d. STREET ADDRESS <u>Rt 2 Box 342</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORBAN HAMILTON RUDY</u>		4. DATE OF DEATH Month Day Year <u>December 25 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 1 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Rudy</u>		14. MOTHER'S MAIDEN NAME <u>Alta Schindler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO <u>206-40-6466</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>approx 30 hours</u>	
18a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 24th</u> , 1959, to <u>Dec 25</u> , 1959, that I last saw the deceased alive on <u>Dec 25th</u> , 1959, and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>David N. Roll</u>		DATE SIGNED <u>Dec 25 1959</u>	
PHYSICIAN'S NAME (Type) <u>Clinton, Md</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-29-59</u>	<u>St. Lincolns</u>	<u>Columbia Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee - Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 1959</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



14122

## CERTIFICATE OF DEATH

Reg. Dist. No.

14070

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>COLUMBIA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOVE</b> Middle <b>----</b> Last <b>RYAN</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 DECEMBER 1959</b>		9. AGE (In years last birthday) <b>4</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>40</b>	IF UNDER 24 HRS Min. <b>40</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>RONALD HARVEY RYAN</b>				14. MOTHER'S MAIDEN NAME <b>JERILYN STONE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		INFORMANT <b>CHART</b>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATELECTASIS</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PREMATURITY</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>1 DAY</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 DECEMBER, 1959</b> , to <b>5 DECEMBER, 1959</b> , that I last saw the deceased alive on <b>5 DECEMBER, 1959</b> , and that death occurred at <b>1:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Arnold A. Abramo</i>		ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b>				DATE SIGNED <b>5 DEC 59</b>	
PHYSICIAN'S NAME (Type) <b>ARNOLD A ABRAMO CAPT USAF MC</b>		USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH 25					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Not given</b>		22c. NAME OF CEMETERY OR CREMATORY <b>District Morgue</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>---</b>				ADDRESS		24a. RECEIVED BY REGISTRAR DATE <b>DEC 10 59</b>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur J. Flanagan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





14084

## CERTIFICATE OF DEATH

Reg. Dist. No.

14080

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Reside before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>29 Hr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>Rt. 3 Box 234</b>	
3. NAME OF DECEASED (Type or print) <b>Paul</b> <b>Mary Louise Savoy</b> <b>Julius</b> <b>Savoy</b>		4. DATE OF DEATH <b>Dec. 12</b> <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11</b>
9. AGE (In years last birthday) <b>29</b>		10. IF UNDER 1 YEAR <b>29</b> Months	11. IF UNDER 24 HRS <b>29</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Paul Clements Proctor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise Savoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 11</b> , <b>59</b> , to <b>Dec. 12</b> , <b>19 59</b> that I last saw the deceased alive on <b>Dec. 12</b> , <b>1959</b> , and that death occurred at <b>8P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bertha G Van Gelderen, M.D.</b>		ADDRESS (Street, city or town, state) <b>3001 Cheverly Ave. Cheverly, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Bertha G Van Gelderen, M.D.</b>		DATE SIGNED <b>DEC 21 '59</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 15, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

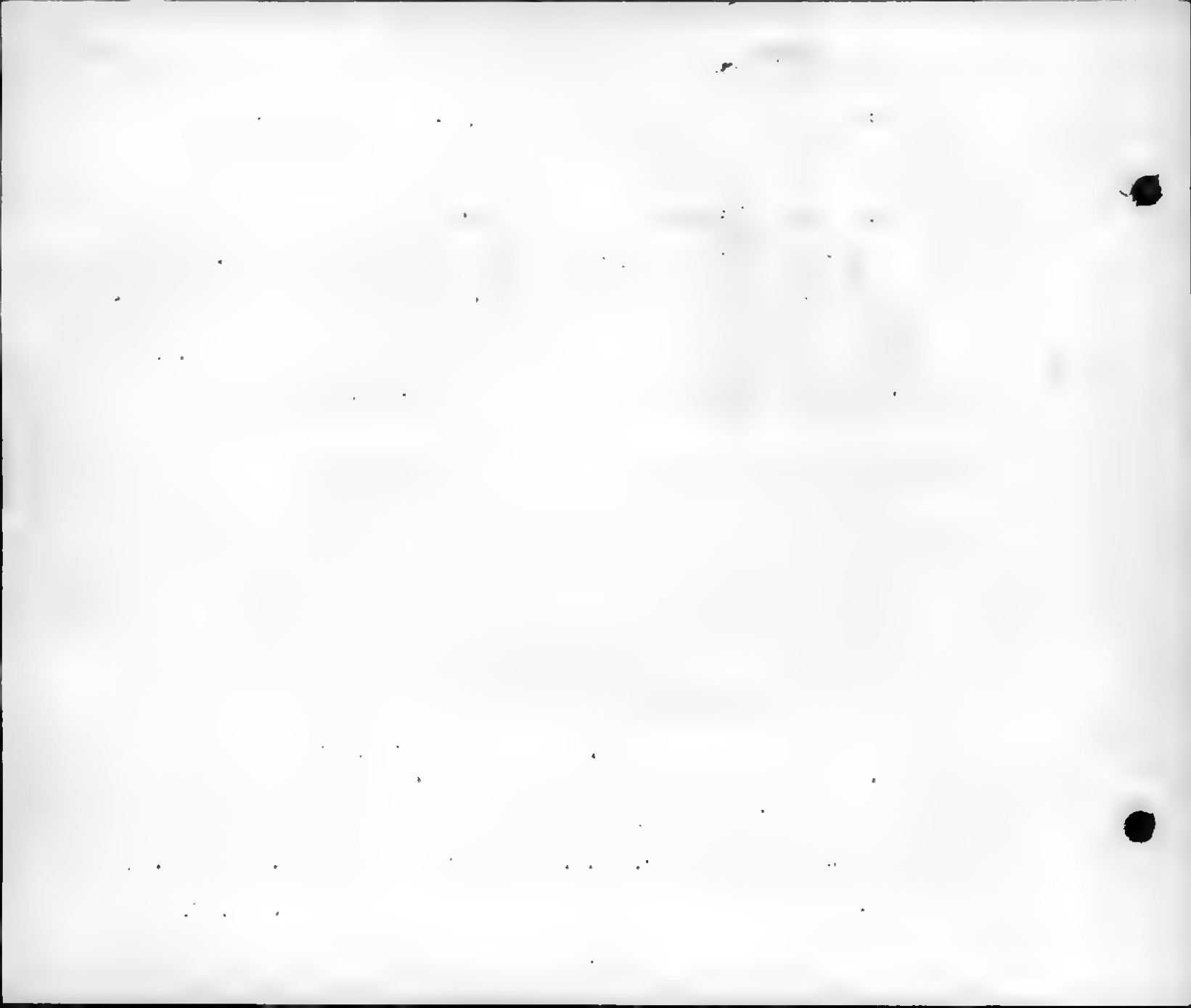
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

10-5-2X10



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14081

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14085

Item 7 Film 6253 12-21-59 et

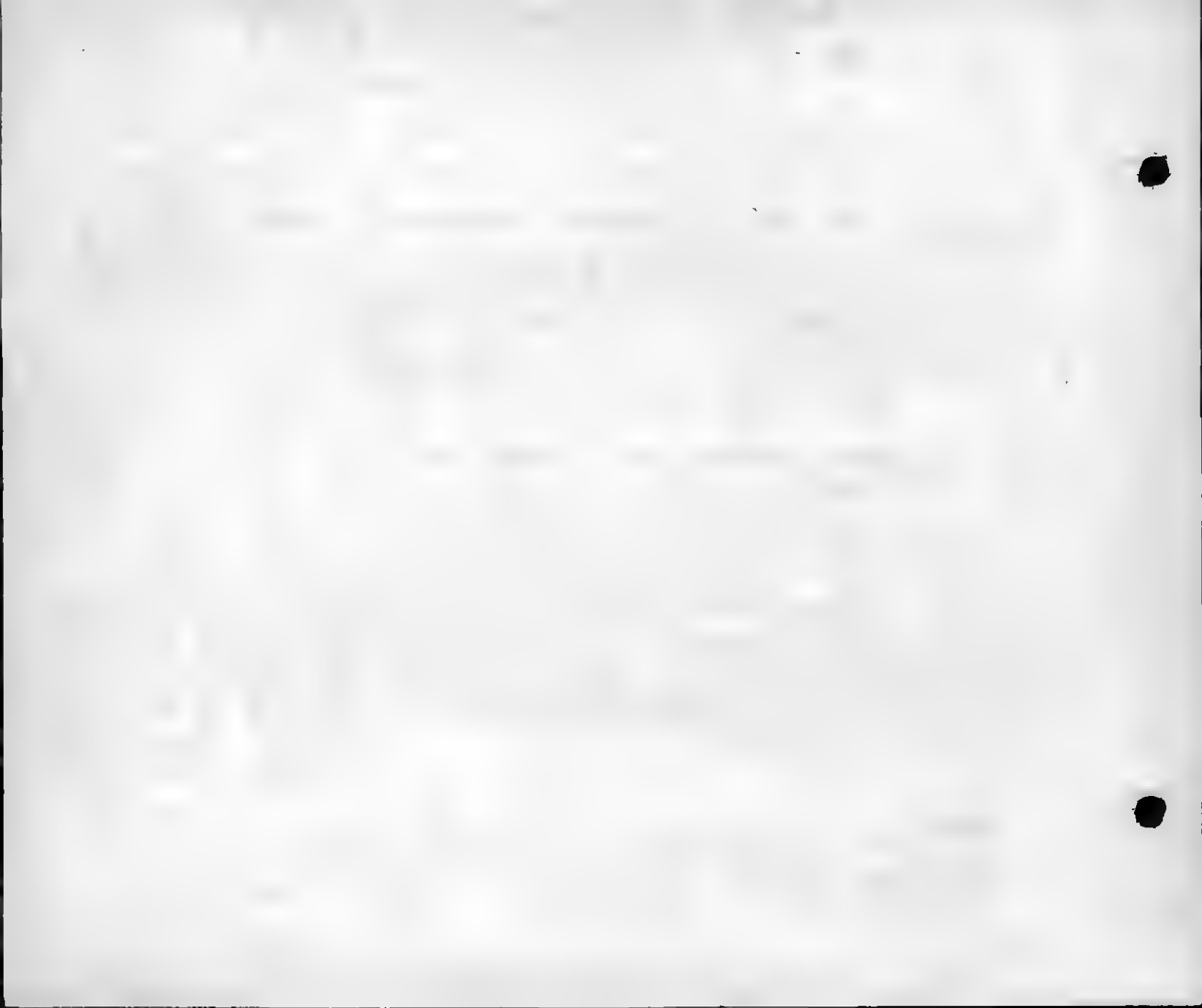
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>		c. LENGTH OF STAY IN 1b <u>10 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				1. d. STREET ADDRESS <u>14601 - Lewis Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Schaefer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Health Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William John Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>Anna Butterworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>577-44-5518</u>		17. INFORMANT <u>Gladys G. Helman - Southland</u>		Address <u>4109 W. ...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>442X</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-12-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James S. ...</u>				ADDRESS <u>317 Pa Ave S.E. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.



14086

## CERTIFICATE OF DEATH

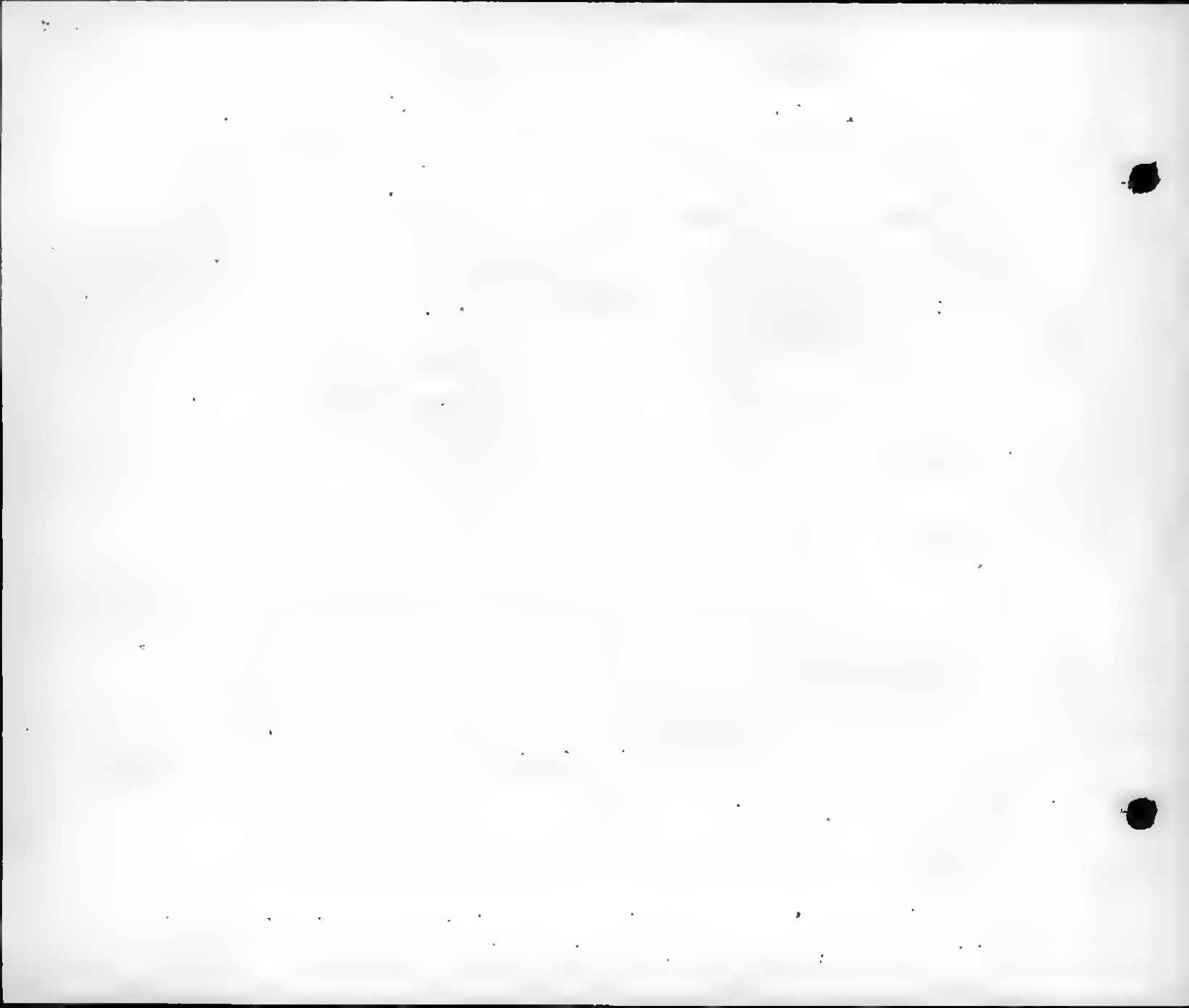
Reg. Dist. No.

14082

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princes Georgesz Cheverly</b>		c. LENGTH OF STAY IN lb <b>12 hrs x</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Princes Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>Rt 1 Box 158</b>					
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>		First <b>Slater</b>		Middle <b>Slater</b>		Last <b>Slater</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 7, 1957</b>		9. AGE (In years last birthday) yrs <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Franklin ALEXANDER</b>				14. MOTHER'S MAIDEN NAME <b>Doris ROSALIE YOUNG</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>MOTHER Box 158 Rt. 1 AQUASCO</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776 x</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Dec 7, 1959</b> to <b>Dec 7, 1959</b> that I last saw the deceased alive on <b>Dec 7, 1959</b> , and that death occurred at <b>10:00 PM</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Betha S. Paulk, M.D.</b>		ADDRESS (Street, city or town, state) <b>3001 Avenue G, Cheverly, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Betha S. Paulk</b>		DATE SIGNED <b>12/8/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>12/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W Penn Mr.</b>		ADDRESS <b>Administrator.</b>		24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-4-60 et

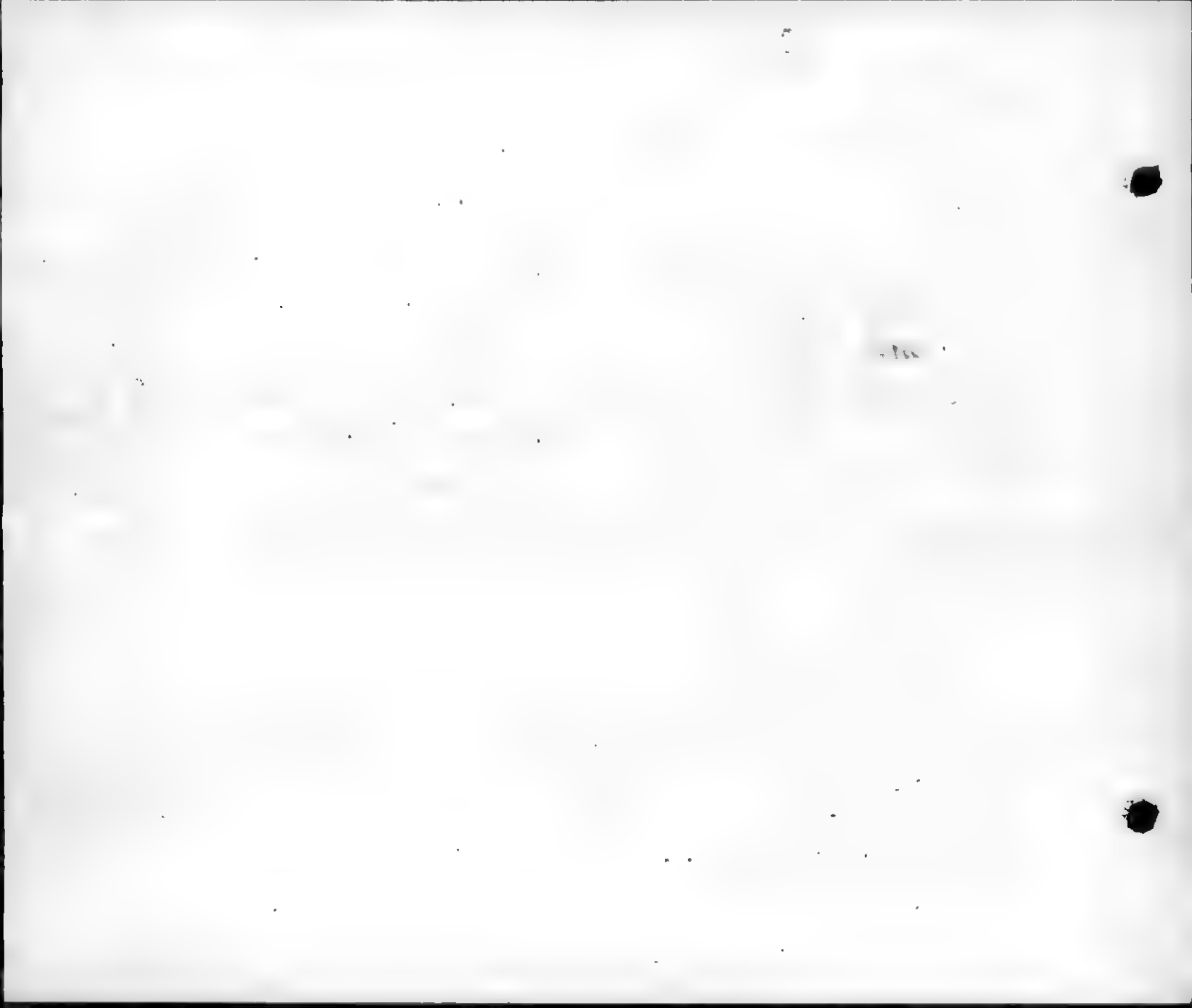
CERTIFICATE OF DEATH

Reg. Dist. No.

14083

14087

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>15 Min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cottage City</b> d. STREET ADDRESS <b>4014 Parkwood St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First Middle Last 4. DATE OF DEATH <b>Dec. 27 19 59</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 4, 1878</b> 9. AGE (In years last birthday) yrs. <b>81 80</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>WASH D.C.</b> 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph A Souder</b> 14. MOTHER'S MAIDEN NAME <b>DORA C. Beckeweg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>220-34-4152</b> 17. INFORMANT <b>ABBBIE E. Souder</b> Address <b>Brentwood M.D. 4014 Parkwood St</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occ curam</b> 4. 2.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis heart disease</b> DUE TO (c) <b>year</b> INTERVAL BETWEEN ONSET AND DEATH <b>about</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 27 1959</b> , to <b>Dec 27 1959</b> , that I last saw the deceased alive on <b>Dec 27 1959</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>T. S. Bergman</b> M.D. <b>4314 Federal St Hyattsville</b> PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b> <b>Mayland</b>			
22a. BURIAL, CREMATION, or other disposition <b>12/30/59</b> 22b. DATE THEREOF <b>12/30/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b> 22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 44 West Ave NE</b> ADDRESS 24a. REC'D BY REGISTRAR DATE <b>DEC 29 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Film 254 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1-5-6 ams Item 2 Film 254 1-4-65 et

14123

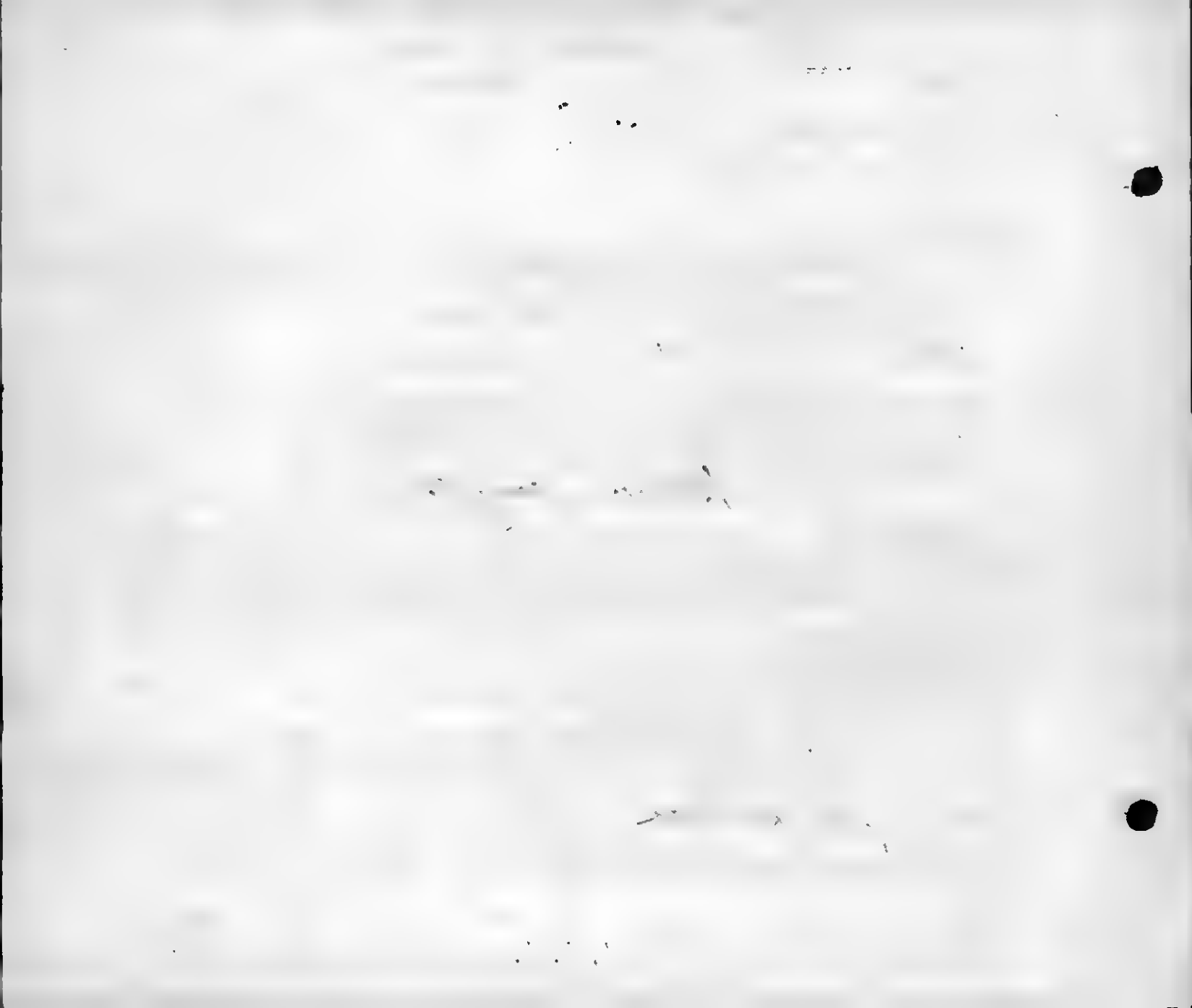
# CERTIFICATE OF DEATH

Reg. Dist. No.

141064

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND D.C. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN b 2 hrs 14 mins				d. STREET ADDRESS 3865 Halley Terr. J.B. 1 ANDREWS AFB, WASH. 25, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews AFB				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SUSAN K. Staten				4. DATE OF DEATH December 25 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 Dec. 1959	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Staten				14. MOTHER'S MAIDEN NAME THEOA K. PALMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis, congenital						two hours	
60.4 DUE TO						and	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diaphragmatic hernia						14 minutes	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 DEC., 1959, to 25 DEC., 1959, that I last saw the deceased alive on 25 DECEMBER 1959, and that death occurred at 5:32 PM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE John A. Moore M.D.				USAF HOSPITAL ANDREWS ANDREWS AFB WASH. 25, D.C. 25 DEC 59			
PHYSICIAN'S NAME (Type) JOHN A. MOORE, CAPT USAF MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Byesville, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home Washington 2, D. C.				24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE	

200 - 22X16



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

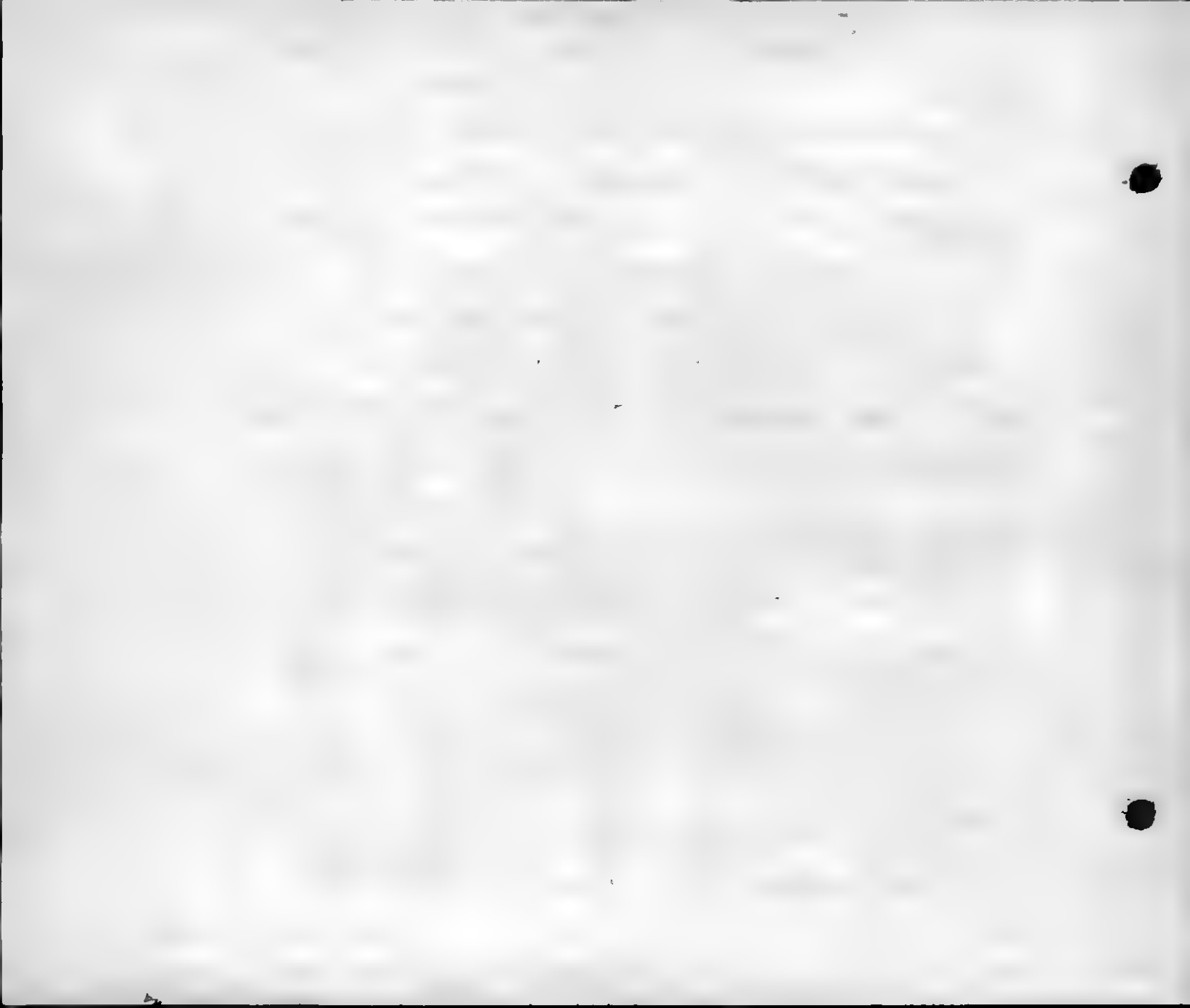
## 1408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14085

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u> c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hall</u> d. STREET ADDRESS <u>Boyer Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Keith Douglas Stevens</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>12-23-1959</u> Month Day Year			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Col</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8-26-58</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>							
<b>13. FATHER'S NAME</b> <u>John J. Stevens</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lavinia Johnson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Army Stevens, same address</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Inanition</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>John T. Maloney</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>John T. Maloney, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>DEC-23-1959</u>				<b>DATE SIGNED</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>22b. DATE THEREOF</b> <u>Dec 26/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Elizabeth's Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. F. Johnson</u> ADDRESS <u>Amnaples</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DEC 29 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Carlton B. K...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14124

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

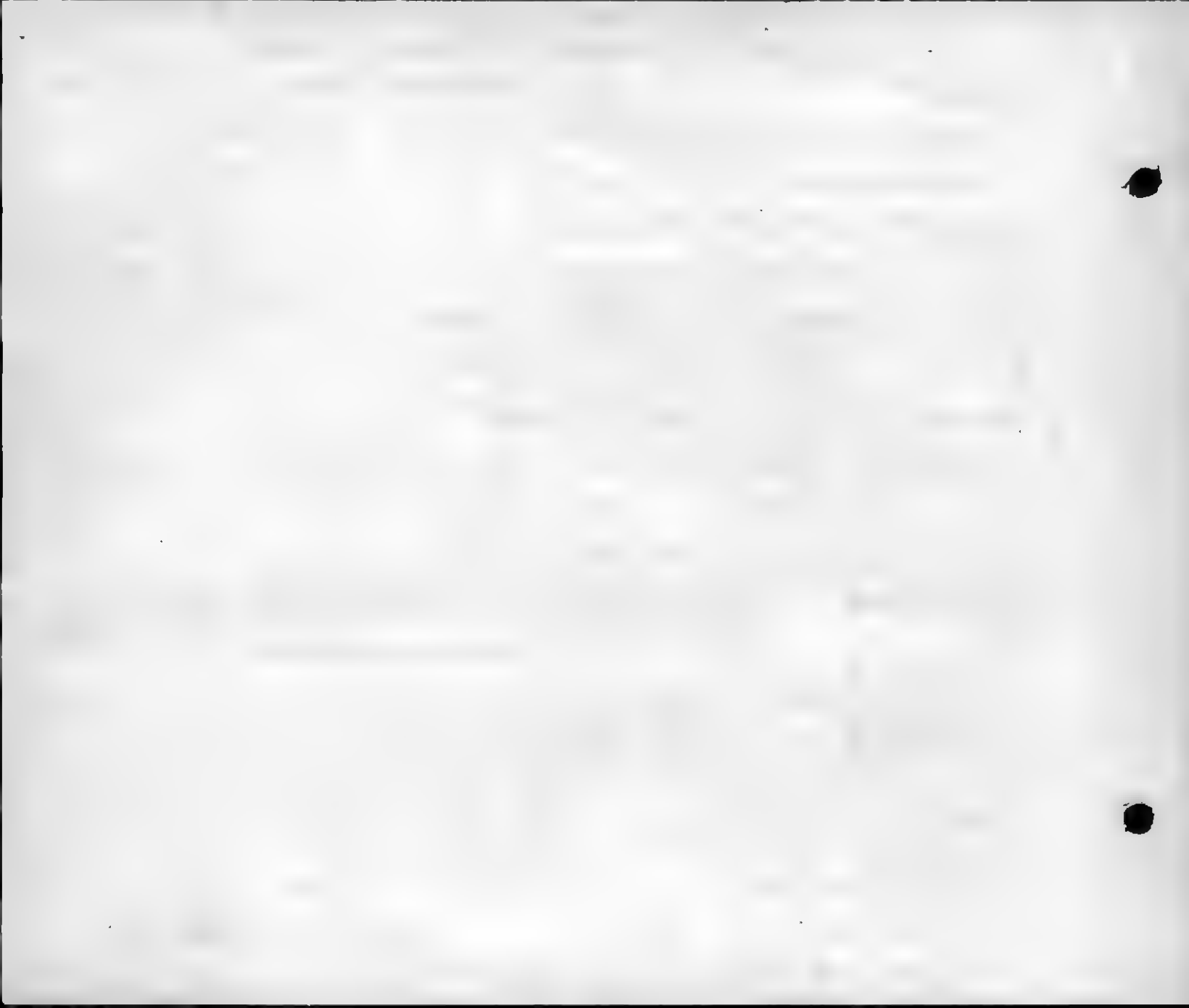
Reg. Dist. No.

14086

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>			
c. LENGTH OF STAY IN 1b <u>6 days</u>				d. STREET ADDRESS <u>5408 - Handerson Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Stoner</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 6, 1878</u>	
9. AGE (in years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done, adapting most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Stoner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Brockers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Walcott W. Gibson</u> Address <u>Annas #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrothrombosis</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Dec 30 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Knox Lido Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stie - Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Nelson</u> ADDRESS <u>254 Central St. - P.O.</u>				24a. REC'D BY REGISTRAR <u>DEC 30 '57</u>		24b. REGISTRAR'S SIGNATURE <u>James I. Boyd</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



## CERTIFICATE OF DEATH

Reg. Dist. No.

14125

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill Md</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>4931-LIVINGSTON ROAD S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>HERBERT</u> Middle <u>TALBERT</u> Last		4. DATE OF DEATH <u>Dec. 8th</u> 19 <u>59</u> Month <u>Dec.</u> Day <u>8th</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 5-1880</u> 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>Oxon Hill, Md.</u>
13. FATHER'S NAME <u>JONATHAN P. TALBERT</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE E CisseL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>SALLIE ANN TALBERT #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>49 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>58</u> to <u>Dec 8</u> 19 <u>59</u> that I last saw the deceased alive on <u>Dec 8</u> 19 <u>59</u> , and that death occurred at <u>6 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert W. Sotsky</u> M.D.		ADDRESS (Street, city or town, state) <u>101 Sudley Lane SE Wash 21100</u> DATE SIGNED <u>12/8/59</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT W. SOTSKY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Landover, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Brothers</u> ADDRESS <u>1661-gd Pope Rd SE</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 10 1959





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

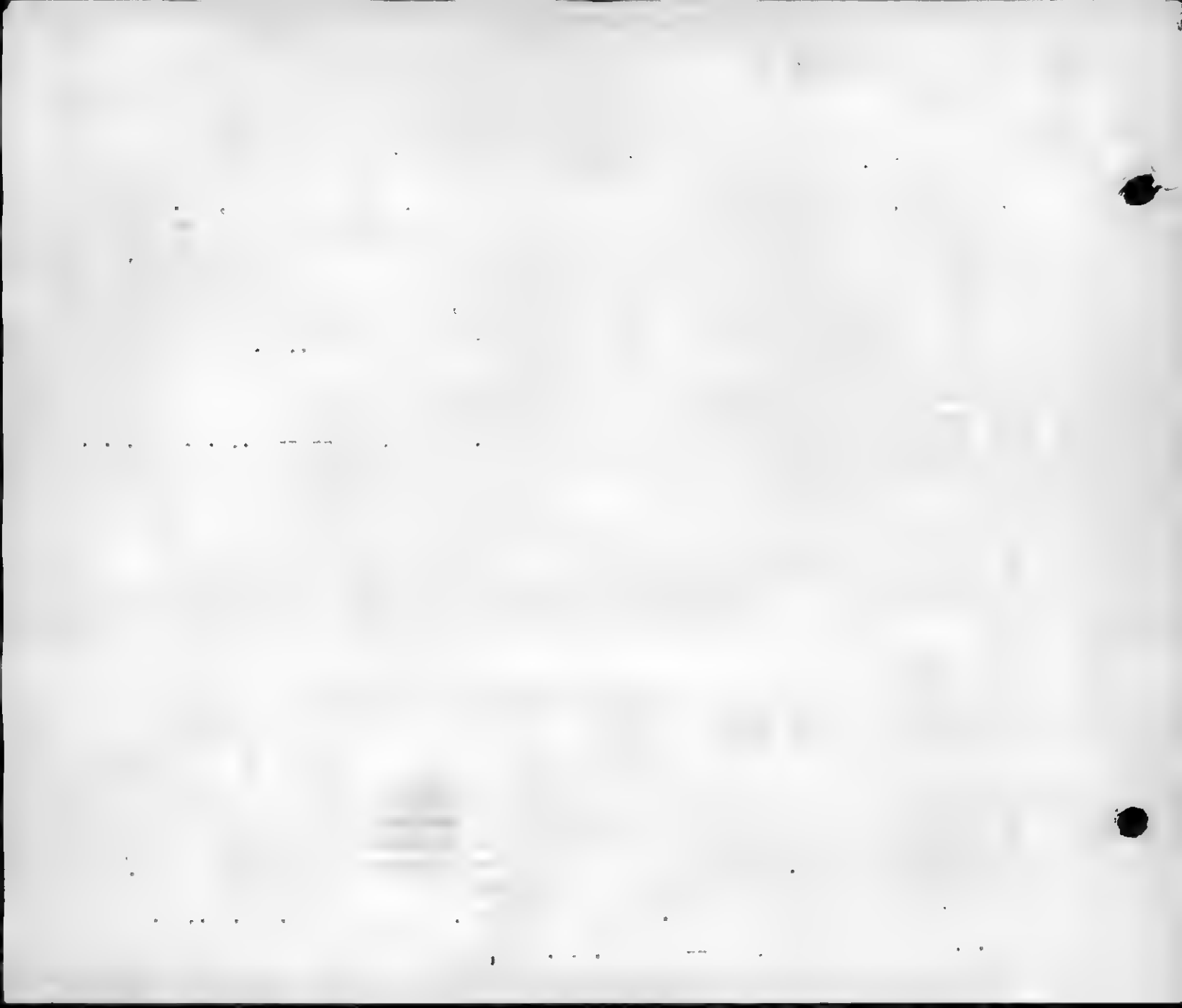
14083

14126

 FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosaryville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route # 1, Upper Marlboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosaryville (Rural)</b>	
3. NAME OF DECEASED (Type or print)      First      Middle      Last <b>GEORGE      THOMAS      TAYLOR</b>		4. DATE OF DEATH      Month      Day      Year <b>December      25th,      1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7th, 1879</b>
9. AGE (in years last birth day) <b>80 yrs.</b>		10. IF UNDER 1 YEAR      IF UNDER 24 HRS. Months      Days      Hours      Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
12. BIRTHPLACE (State or foreign country) <b>Prince Georges Co., Md.</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>Thomas Marshall Taylor</b>		15. MOTHER'S MAIDEN NAME <b>Mary Ellen Cator</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Maria E. Peters, 602--A--St., N.E. Wash. D.C.</b>		19. ADDRESS <b>602--A--St., N.E. Wash. D.C.</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Universal burns of the body</b> DUE TO (c) <b>second and third degree</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Was in room that caught on fire</b>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Was in room that caught on fire</b>	
22c. TIME OF INJURY      Month, Day, Year <b>1:30 p.m.      12-25-59</b>	22d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	22f. CITY OR TOWN (County) (State) <b>Rosaryville P.G. Co. Md.</b>
23. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>12/26/1959</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE THEREOF <b>12/29/1959</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Church Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Croom, Pr. Geo. Co., Md.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Company, 517--11th St. S.E. Wash. DC</b>		26. REC'D BY REGISTRAR <b>DEC 29 '59</b>	
27. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		28.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG253 12-14-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

14089

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sheverly</b> c. LENGTH OF STAY IN lb <b>2 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lakeland</b> d. STREET ADDRESS <b>8113 54th Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>Thomas</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1888</b>	
9. AGE (in years last birthday) <b>71 yrs</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min <b>59</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Agriculture</b>			
13. FATHER'S NAME <b>Andrew Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Hilce Hebron</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Merrill Thomas - 4902 Lakeland Rd.</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic</b> (c) <b>arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertension</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11-29-</b> 19 <b>59</b> , to <b>12-1-</b> 19 <b>59</b> that I last saw the deceased alive on <b>Dec. 1, 1959</b> , and that death occurred at <b>9:25 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Til Bergman</b>				DATE SIGNED <b>Dec 1 1959</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b>				ADDRESS (Street, city or town, state) <b>4319 Seaboard St 1</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Dec. 6 1959</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Meth. Ch. Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Bacon, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Washington</b>				24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>			
ADDRESS <b>467 N. W. 1st St.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>			



## CERTIFICATE OF DEATH

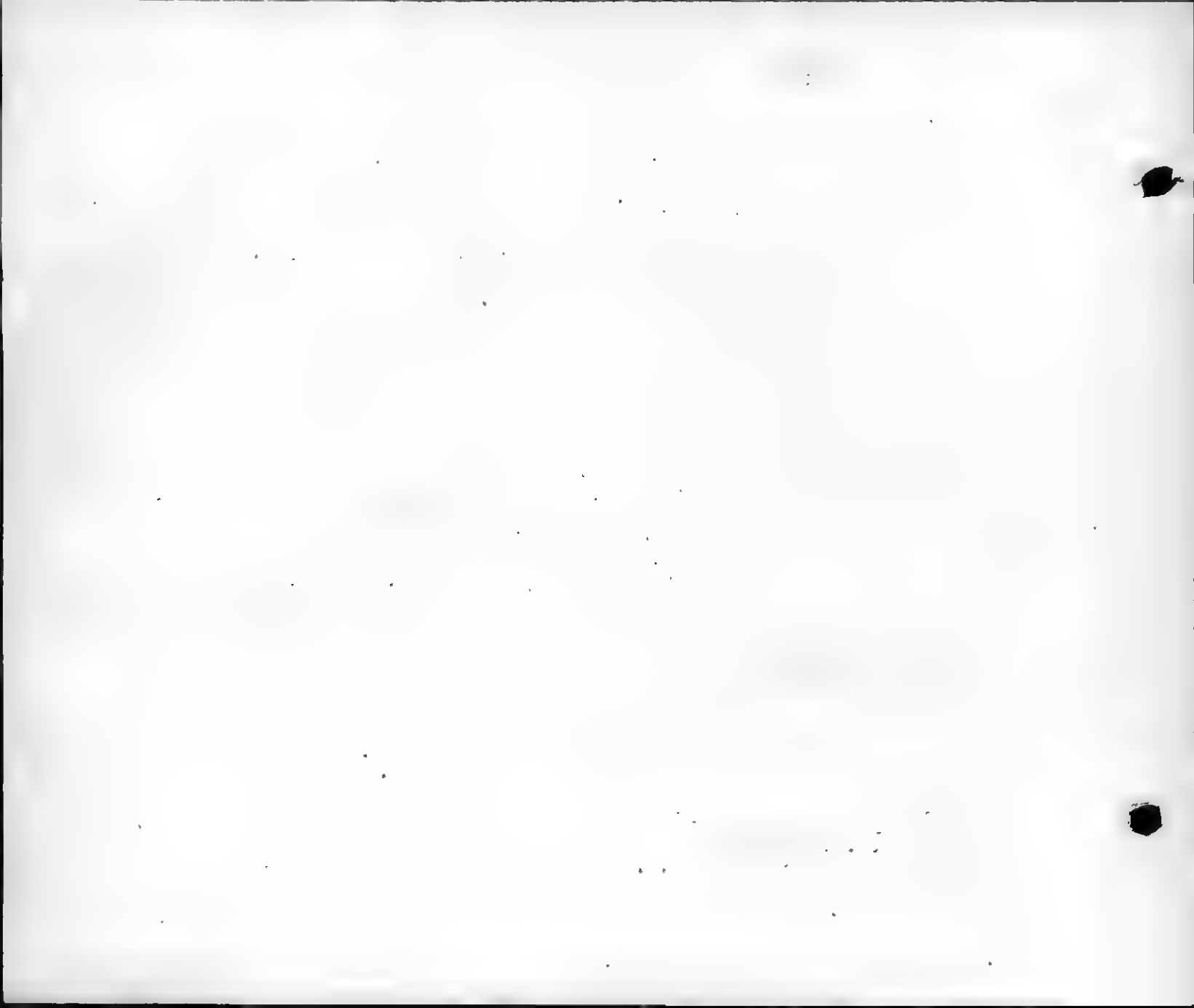
Reg. Dist. No.

14091

14090

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <b>Prince George</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>37 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charlotte</b> Middle <b>D</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 18, 1876</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Rev J H Dudley</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>George Thomas</b>				Address <b>same as no 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>585x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>choleangiolytic disease</b> DUE TO (c) <b>obstructive jaundice</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Oct 1 - 59</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 1</b> , 19 <b>59</b> to <b>Dec 5</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec 5</b> , 19 <b>59</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cottage City Md.</b> DATE SIGNED <b>12-5-59</b>							
ACTUAL SIGNATURE <b>Dr. George Hageage</b> M.D.				ADDRESS (Street, city or town, state) <b>Cottage City Md.</b>			
PHYSICIAN'S NAME (Type) <b>Hageage, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>			
24a. REC'D BY REGISTRAR <b>DEC 9 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14052

14020

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN 1b 30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d. STREET ADDRESS 3306 Otis Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) 3306 - Otis Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter Sharpe Tompkins				4. DATE OF DEATH Dec 6 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Sept. 1885		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Highland N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Henry Tompkins				14. MOTHER'S MAIDEN NAME Adeline Hoxie Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-09-0070		17. INFORMANT Clara E. Manderschied		Address 3306 Otis St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung Mediastinal area 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heavy cigarette smoker for years DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 1957 to Dec 1957, that I last saw the deceased alive on 30 Dec 1957, and that death occurred at 4:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Mattingly, M.D.				ADDRESS (Street, city or town, state) 2206 R. I. Ave N.E. 18			
PHYSICIAN'S NAME (Type) Thomas E. Mattingly, M.D.				DATE SIGNED 6 Dec 59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mackey's Funeral Home				ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR DATE DEC 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



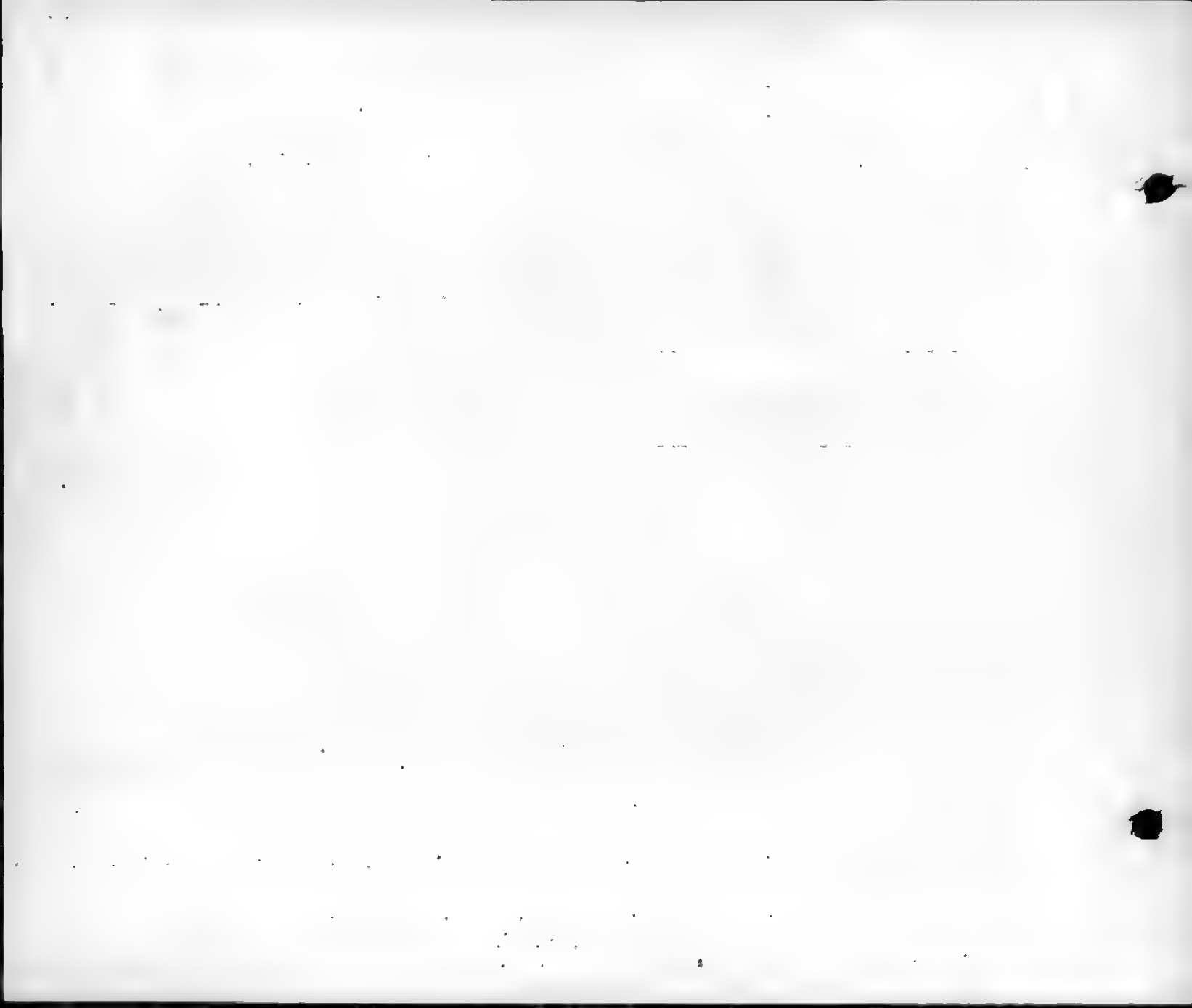


1  
Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14127  
CERTIFICATE OF DEATH

14093  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 27, D.C.</b>	
		d. STREET ADDRESS <b>6229 MARLBORO PIKE</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAURENCE LEE THOMPSON JR</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 3 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 NOVEMBER 1959</b>
9. AGE (In years lost birthday) ____ yrs ____ mos ____ days		10. IF UNDER 1 YEAR Months ____ Days ____	
11. IF UNDER 24 HRS Hours ____ Min ____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>LAURENCE LEE THOMPSON</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN O'Rourke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>773.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PREMATURITY</b> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b> <b>3 DAYS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 DECEMBER</b> , 19 <b>59</b> , to <b>3 DECEMBER</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 DECEMBER</b> , 19 <b>59</b> , and that death occurred at <b>0040A</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>USAF HOSPITAL ANDREWS 3 DEC 59</b>			
ACTUAL SIGNATURE <b>Reginald P McManus</b> M.D. <b>USAF HOSPITAL ANDREWS 3 DEC 59</b>			
PHYSICIAN'S NAME (Type) <b>REGINALD P MCMANUS CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, Wash 25 D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rinaldi Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14094

Reg. Dist. No.

14091

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Dist. of Col.</b> COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
f. STREET ADDRESS <b>230 Rhode Island Ave. N.E.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lee D Totman</b>				4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1876</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John Totman</b>				14. MOTHER'S MAIDEN NAME <b>Charolett Foster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Miss Ariel F. Totman Washington D. C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Surgical procedure for <b>resection</b> of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>103.8</b> (c) <b>Carcinoma of the colon</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				24a. REC'D BY REGISTRAR <b>DATE DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

2

2

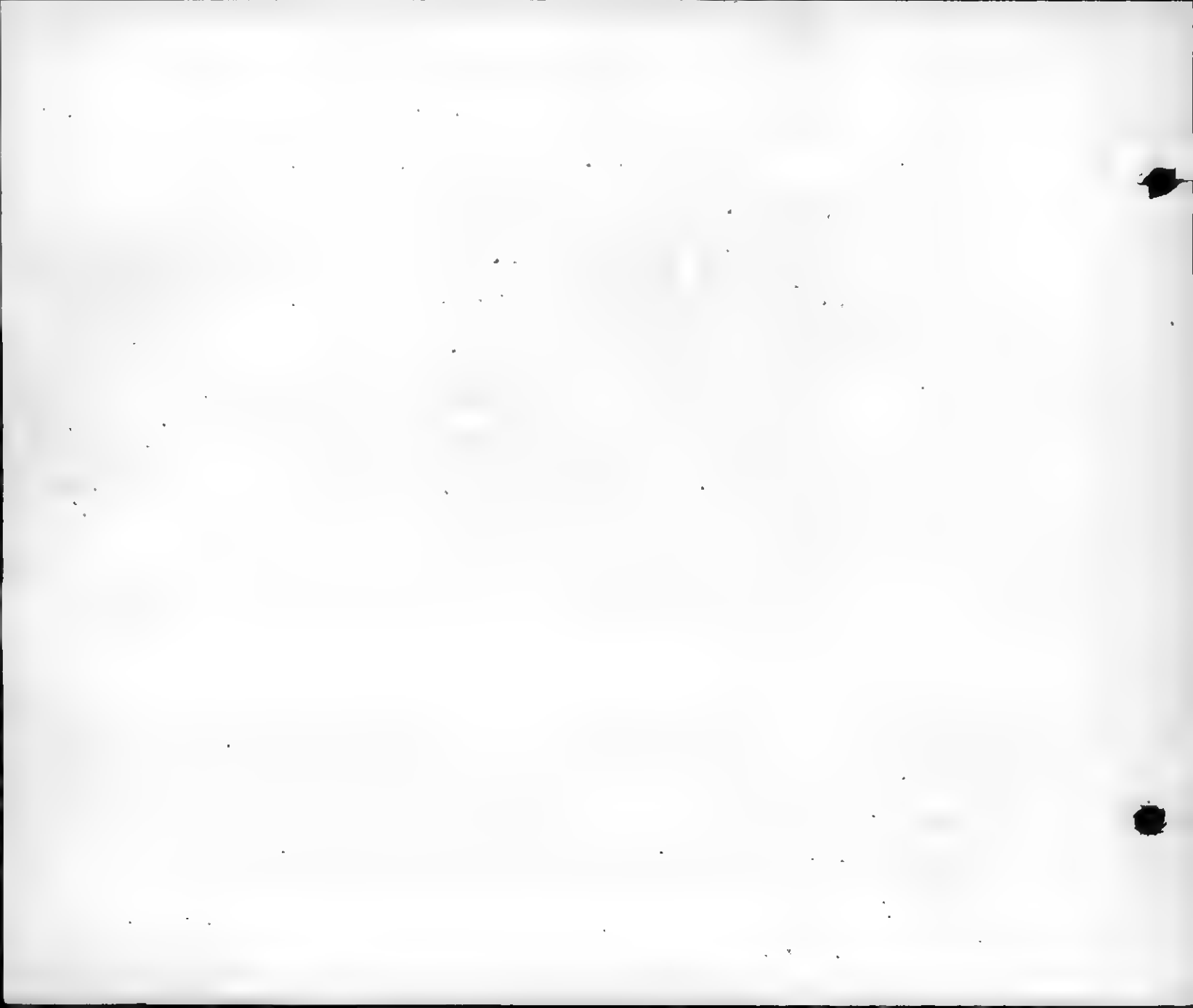
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	Dec 18-59	Lucas Cemetery	Lucas Co., N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
SIMMONS BROS		WASH. D.C. 1661 GOOD HOPE	DATE DEC 18 '59	Arthur L. Hines

VS A15 (4)  
ISM 9/SB



## CERTIFICATE OF DEATH

Reg. Dist. No.

14096

14092

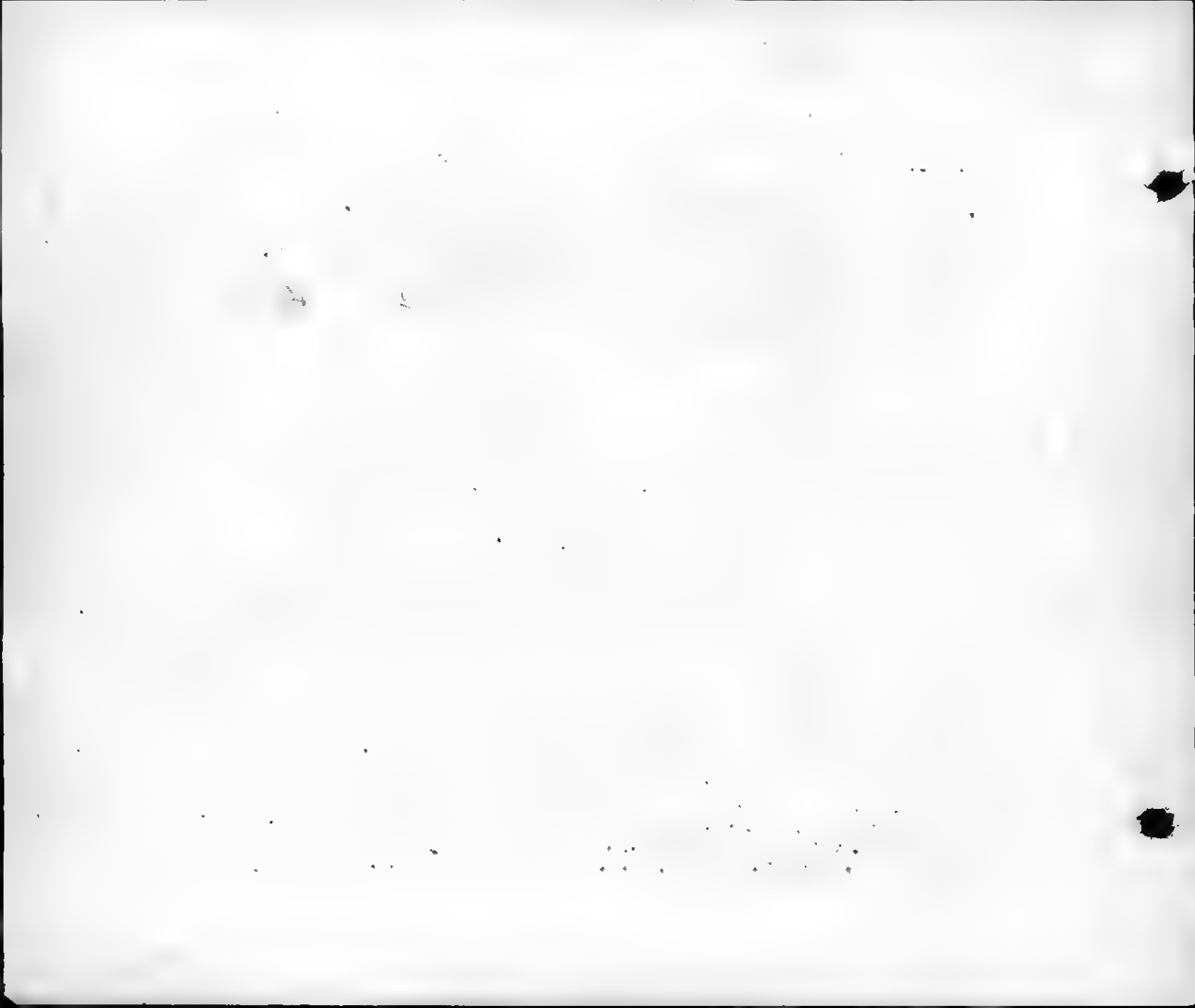
1. PLACE OF DEATH o COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>21 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Vest</b> Last <b>Vest</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1, 1912</b>	
9. AGE (In years and month) <b>46 1/2</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		11. IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WHITE STONE VA</b>	
13. FATHER'S NAME <b>RICHARD F DIX</b>				14. MOTHER'S MAIDEN NAME <b>GLADYS POWELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>ISAAC M VEST</b>				Address <b>SAME AS ITEM 2 -</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic melanoma</b> <b>190.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant melanoma</b> DUE TO (c) <b>13 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. m.</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>Dec. 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 7</b> , 19 <b>59</b> , and that death occurred at <b>10:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3408 Rhode Island Ave</b> DATE SIGNED <b>12/7/59</b>							
ACTUAL SIGNATURE <b>Leon R. Levitsky M.D.</b>				PHYSICIAN'S NAME (Type) <b>Dr. Leon R. Levitsky M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>12-10-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>FT LINCOLN CEM</b>				22d. LOCATION (City, town, or county) (State) <b>BLADENSBURG MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>				24. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>			

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14129

## CERTIFICATE OF DEATH

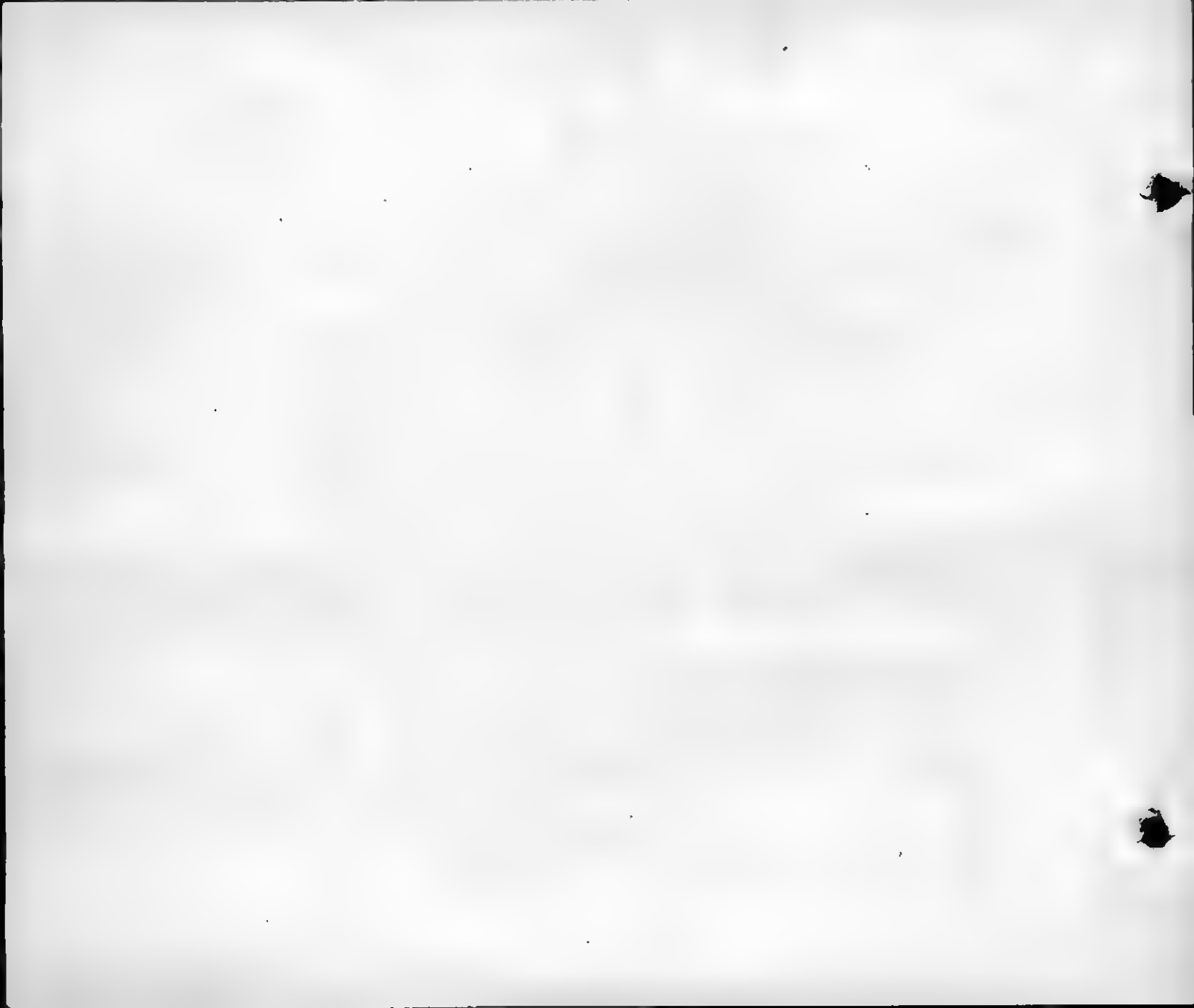
Reg. Dist. No.

14057

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi, Hyattsville 2 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Caroline Watts</u>		4. DATE OF DEATH <u>Dec. 9 1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 28, 1869</u>
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James W. Nichols</u>		14 MOTHER'S MAIDEN NAME <u>Caroline Faulkner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Arteriosclerosis, Generalized</u> <u>400.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1 1959</u> to <u>Dec 9 1959</u> , that I last saw the deceased alive on <u>Dec 6 1959</u> , and that death occurred at <u>7:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock M.D.</u>		ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>12-9-59</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>Theresa Park 12 md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/12/59</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Nichols Memorial Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Odenton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u>		24a. REG'D BY REGISTRAR <u>DEC 14 '59</u>	
ADDRESS <u>Mt. Rainier, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

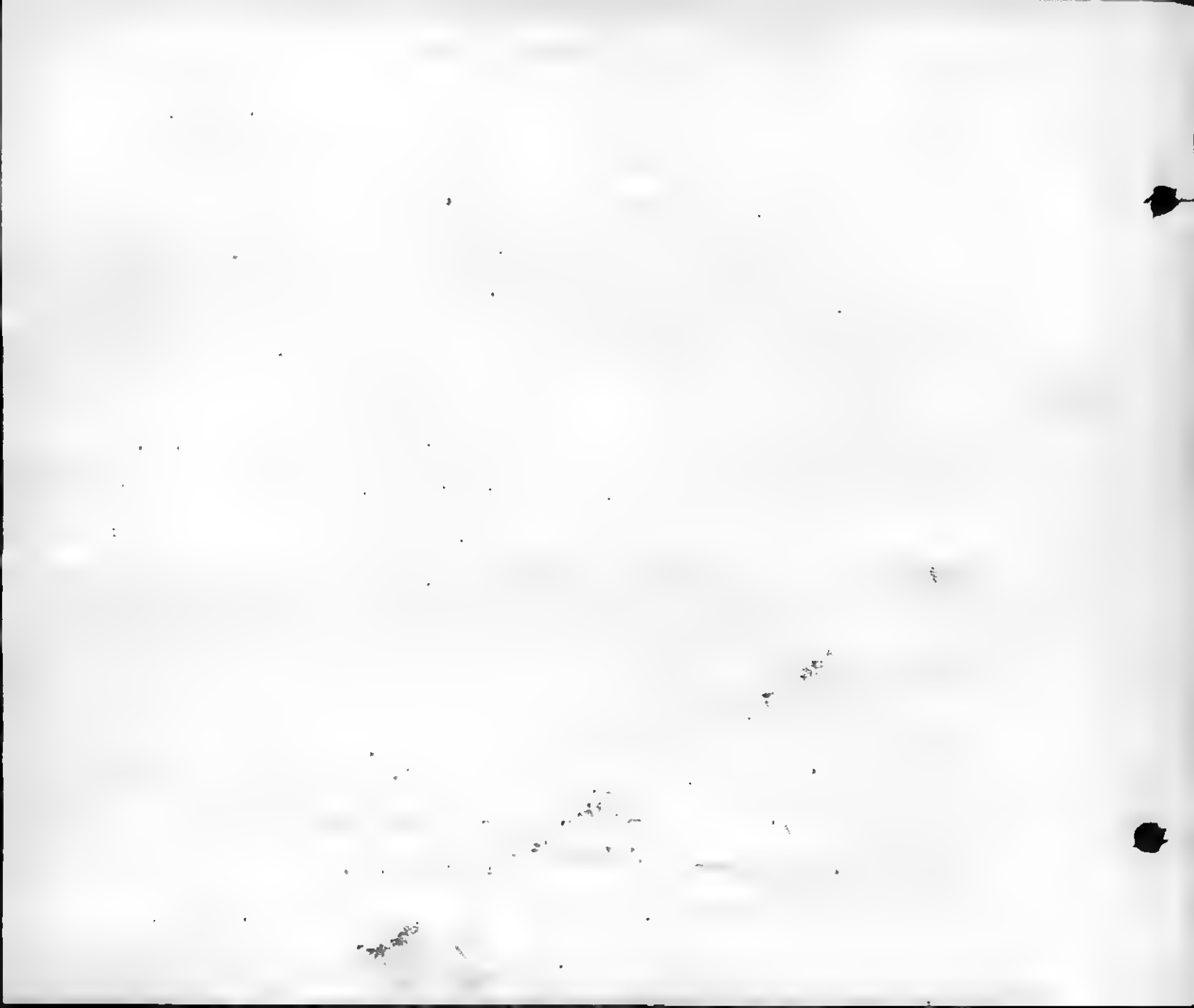
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14093  
CERTIFICATE OF DEATH

Reg. Dist. No. 14098

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>4 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. STREET ADDRESS <b>6006 85th Place</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Carl</b>		First <b>C</b> Middle <b>Weyforth</b> Last <b>Weyforth</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 25, 1888</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Musician</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Weyforth</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Holecek</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Hospital record Washington D. C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis of aorta</b> DUE TO (c) <b>cholesterol crystals</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12h</b> <b>18h</b> <b>2 1/2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 10th</b> , 19 <b>57</b> , to <b>Dec. 17</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec 17th</b> , 19 <b>59</b> , and that death occurred at <b>1:35 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Til Bergman</b>				ADDRESS (Street, city or town, state) <b>3-D Crescent Road</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman</b>				M.D. <b>Green belt, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Dec 19, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. RECEIVED BY REGISTRAR <b>DEC 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>			



## CERTIFICATE OF DEATH

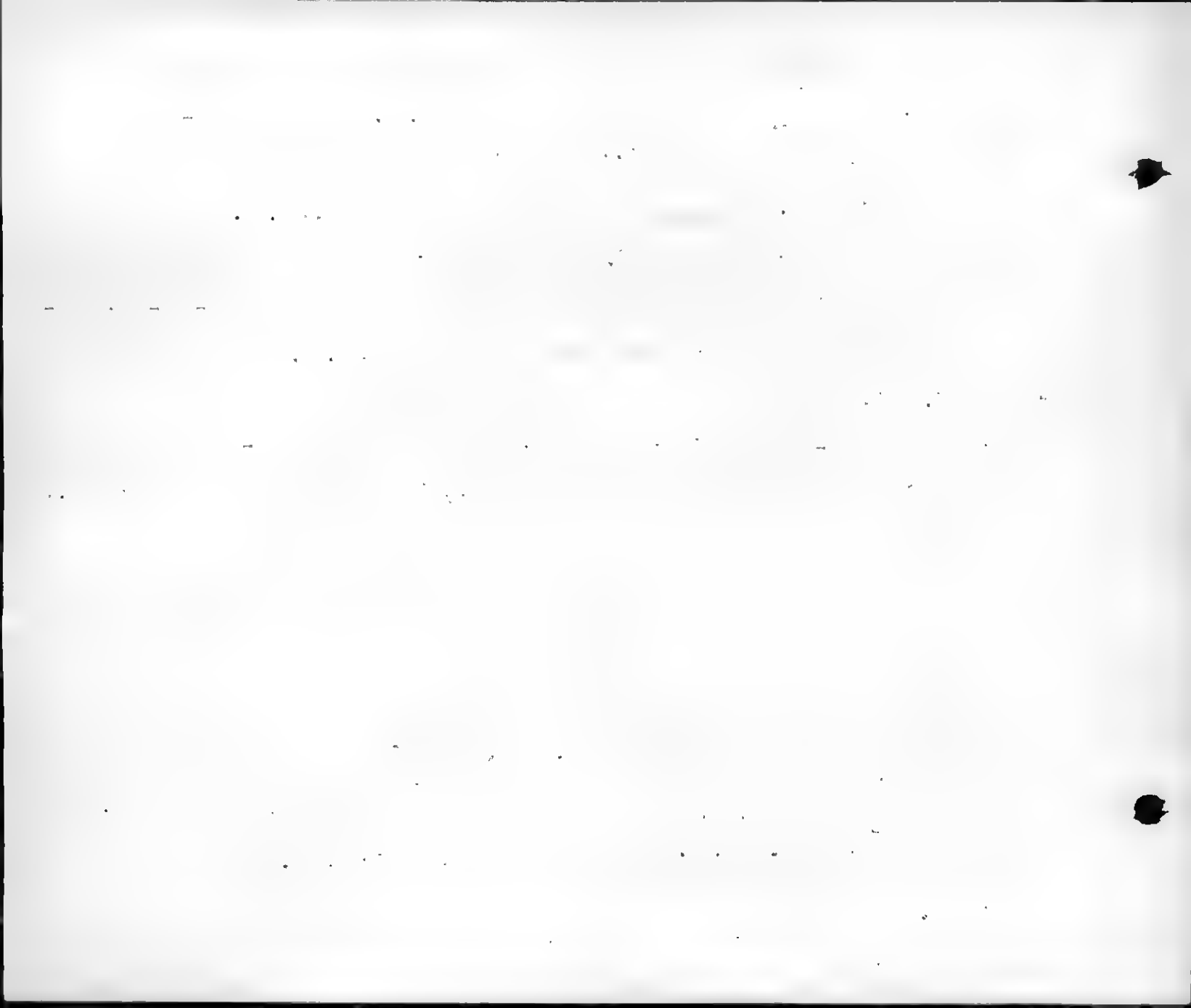
Reg. Dist. No 14099

14130

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>3 yrs., 11 months, &amp; 14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>328 6th St., S. E.</b>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>E.</b> Last <b>Whitehead</b>		4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/7/1872</b>
9. AGE (In years last birthday) <b>87 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>12</b> Days <b>20</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John K. Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Ada Grimes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis, far advanced</b> 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.,</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/6/ 1956</b> to <b>12/20 1959</b> , that I last saw the deceased alive on <b>12/20 19 59</b> , and that death occurred at <b>3:55 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Moe Weiss</i>		DATE SIGNED <b>12/20/59</b>	
PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		Glenn Dale Hospital <b>Glenn Dale, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CONGRESSIONAL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Michael J. Luciani</i>		24a. REC'D BY REGISTRAR <b>RINALDI FUNERAL HOME</b> <b>816 H ST NE, WASH, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

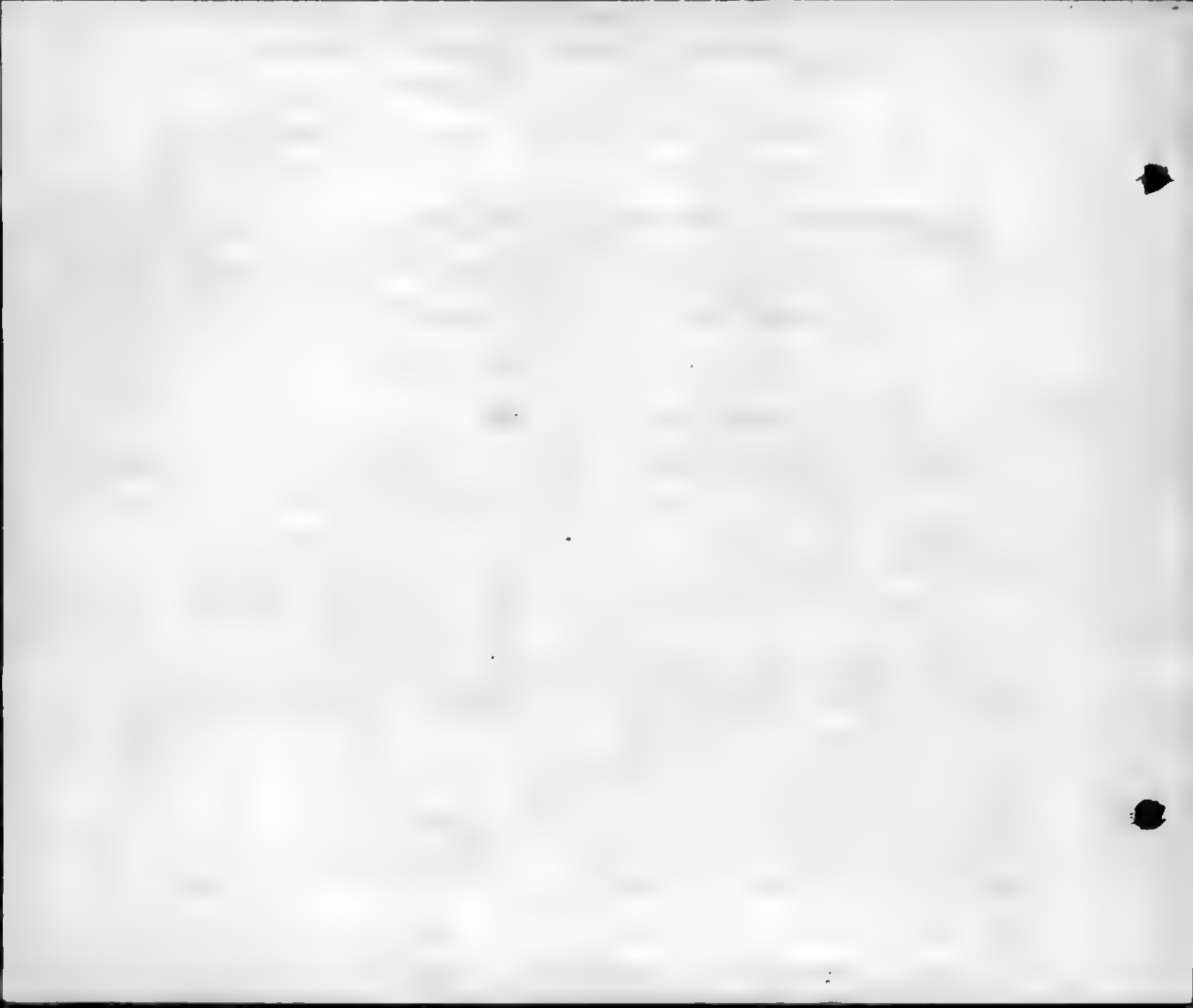
14100

Reg. Dist. No.

14131

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southland</u> c. LENGTH OF STAY IN 1b <u>26 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4715 1/2 Summer Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southland</u> d. STREET ADDRESS <u>14715 1/2 Summer</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Joseph Hughes Williams</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Dec 13 1959</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec 11, 1883</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Skilled Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Railway Express</u>		<b>11. BIRTHPLACE</b> (State or foreign county) <u>Centret of Columbia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>	
<b>13. FATHER'S NAME</b> <u>John D. Williams</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Irene Cooper Smith</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Mrs Elizabeth Williams same as H7</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>Dec 13, 1959</u>	
<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. BOYD</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					
<b>22b. DATE THEREOF</b> <u>12/16/59</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>				<b>22d. LOCATION (City, town, or county) (State)</b> <u>Prince Georges Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers Jr.</u>				<b>ADDRESS</b> <u>517 11th St. S.E.</u>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>DEC 17 '59</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kraus</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





14094

## CERTIFICATE OF DEATH

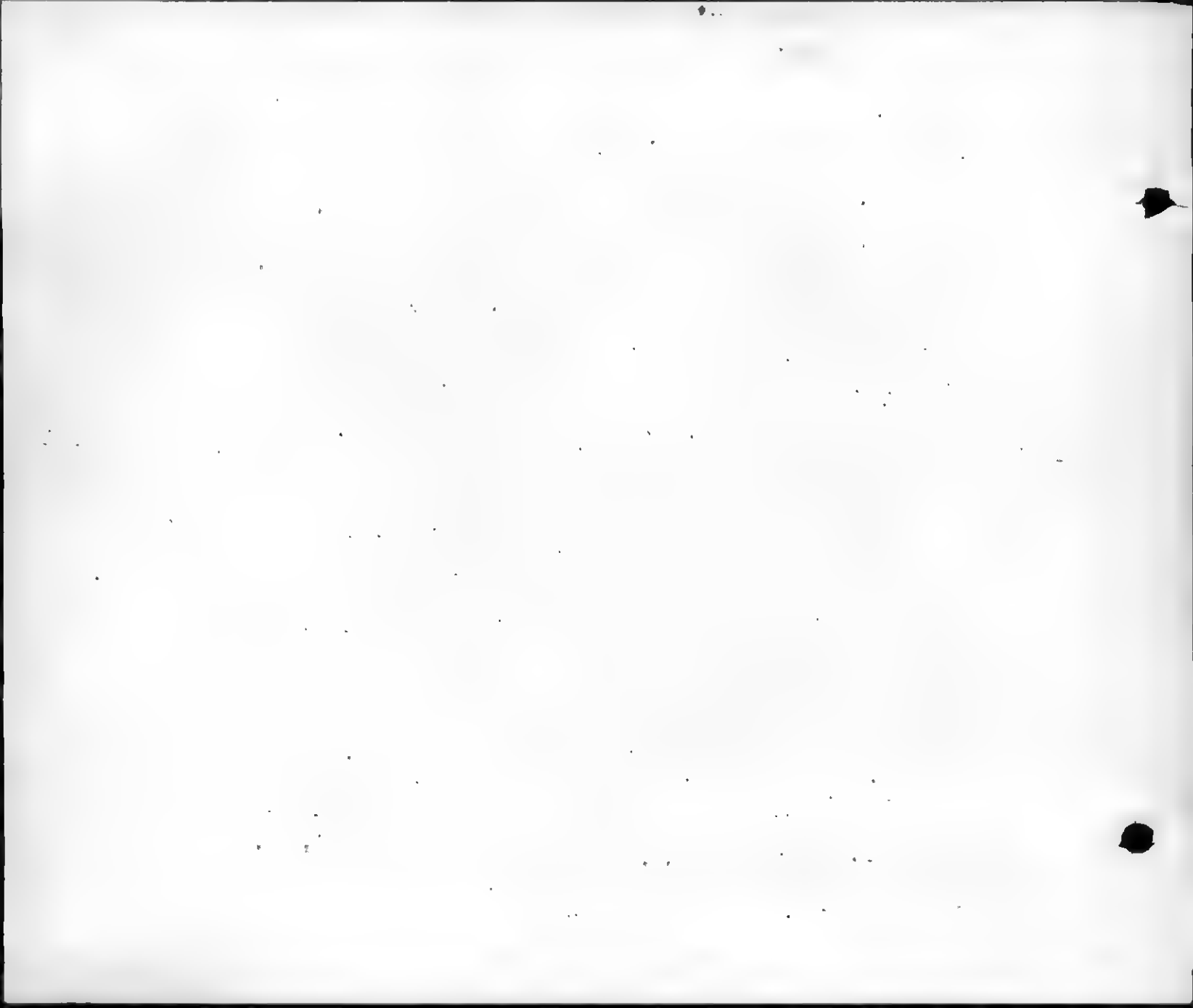
Reg. Dist. No.

14111

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Uneverly</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>	
c. LENGTH OF STAY IN 1b <b>1 Month</b>		d. STREET ADDRESS <b>9511 Sheridan St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine</b> First <b>M</b> Middle <b>Willis</b> Last		4. DATE OF DEATH <b>Dec. 26</b> 19 <b>59</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1875</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD BRAHLER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE DONOHUE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>578-48-5894</b>	
17. INFORMANT <b>MRS. THELMA GRANEY</b>		Address <b>9511-SHERIDAN ST SEABROOK ACRES MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.1</b> DUE TO <b>pulmonary embolism</b>			
(b) <b>Thrombosis of right auricular appendage</b> DUE TO <b>immature fibrillation</b> 1 month			
(c) <b>1. month</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arterio-sclerotic heart disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 26</b> , 19 <b>59</b> , to <b>Dec. 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 26</b> , 19 <b>59</b> , and that death occurred at <b>2:15 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. Bergman</b>		DATE SIGNED <b>3 D Cresent Rd Greenbelt, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) - <b>12/30/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Phelaffell</b>		24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>	
ADDRESS <b>475-H-7th St</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14095

## CERTIFICATE OF DEATH

Reg. Dist. No.

14102

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mattie C. Wilson</u>		4. DATE OF DEATH <u>Dec. 25 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Graniteville - S. Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John H. Coursey</u>	
14. MOTHER'S MAIDEN NAME <u>Lucinda Cook</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John J. Wilson - 2737 Devonshire Place N.W. - Washington - D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4-11-1 DUE TO (b) <u>Auricular Fibrillation</u> Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO (c) <u>Cerebral Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>over 3 yrs.</u> <u>many yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 24</u> , 19 <u>58</u> , to <u>Dec. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>59</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Coggins - M.D.</u>		DATE SIGNED <u>12/25/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co 2901-14th St N.W.</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

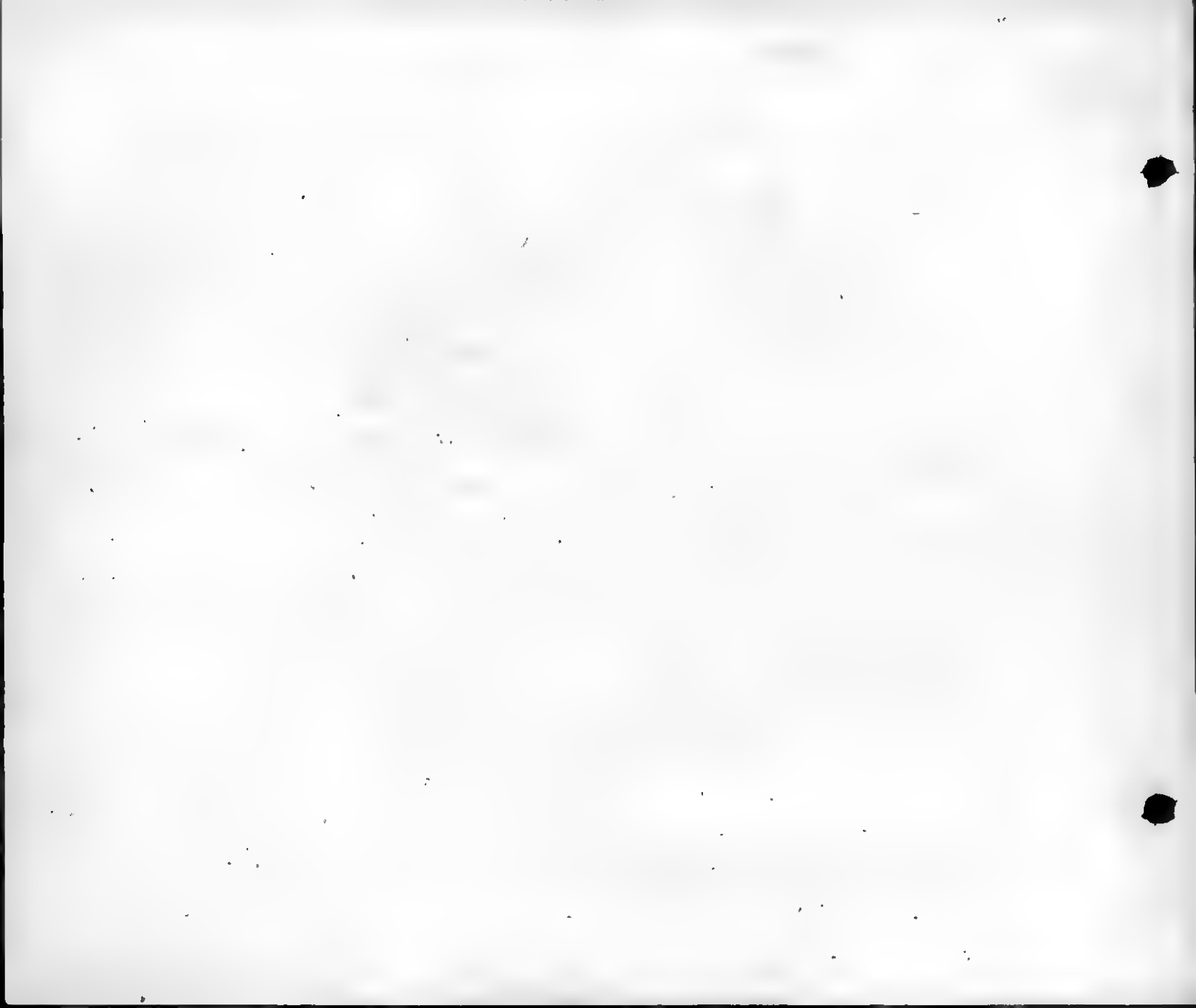
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14132

CERTIFICATE OF DEATH

Reg. Dist. No.

14193

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>11 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON, DC</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47x-3</b> d. STREET ADDRESS <b>607 BRANDYWINE STREET, SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>B</b> Last <b>YESULAITIS</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 SEPTEMBER 1882</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA-RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>							
13. FATHER'S NAME <b>JOHN BALANDA</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JOHN F YESULAITIS (SON)</b> Address <b>706 BRANDYWINE STREET, WASHINGTON, DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE WITH INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>20 YEARS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 DECEMBER 1959</b> , to <b>15 DECEMBER 1959</b> , that I last saw the deceased alive on <b>15 DECEMBER 1959</b> , and that death occurred at <b>0200 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>USAF HOSPITAL ANDREWS 15 DECEMBER 59</b>							
ACTUAL SIGNATURE <b>John F. Bridgeman</b> M.D.				PHYSICIAN'S NAME (Type) <b>JOHN F BRIDGEMAN, CAPT, USAF, MC</b> <b>USAF HOSPITAL ANDREWS, WASHINGTON 25, DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12-19-59</b>		<b>St Josephs</b>		<b>Summit Hill Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Mattingly, 131 - 11th St., S.E.</b> <b>Washington 3, D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of developing a business plan is to conduct a thorough market research. This involves identifying the target market, understanding their needs and preferences, and analyzing the competitive landscape. Market research can be conducted through various methods, including surveys, interviews, and focus groups. The goal is to gather valuable insights that will inform the business strategy and help identify potential opportunities and challenges.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11 & 12 Film G253 12/24/59 iwk

14096

CERTIFICATE OF DEATH

Reg. Dist. No.

14104

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Arthur</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 June 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Young</b>	
14. MOTHER'S MAIDEN NAME <b>Pricilla</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <b>Mary Young</b> Address <b>7137 Whitehouse Rd. Ritchie, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chemia</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute pyelonephritis with abscess formation</b> DUE TO (c) <b>Prostatic hypertrophy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-14</b> , 19 <b>59</b> , to <b>12-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-14</b> , 19 <b>59</b> , and that death occurred at <b>5.00A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James B. Backrach M.D.</b>		ADDRESS (Street, city or town, state) <b>915 - 19th Street, N.W. Wash. DC.</b>	
PHYSICIAN'S NAME (Type) <b>Louis B. Backrach, M.D.</b>		DATE SIGNED <b>12/14/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Simon</b>		22d. LOCATION (City, town, or county) (State) <b>Croome, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Backrach</b>		ADDRESS <b>915 - 19th Street, N.W.</b>	
24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. S. Hines</b>	

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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